United States v. State of Texas

Monitoring Team Report

Rio Grande Center

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Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with intellectual and developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers the 12 State Supported Living Centers (SSLCs), Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio, and the Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

In 2009, the parties selected three Independent Monitors, each of whom was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that were submitted to the parties. Each Monitor engaged an expert team for the conduct of these reviews.

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures.

Given the intent of the parties to focus upon outcomes experienced by individuals, some aspects of the monitoring process were revised, such that for a group of individuals, the Monitoring Teams' reviews now focus on outcomes first. For this group, if an individual is experiencing positive outcomes (e.g., meeting or making progress on personal goals), a review of the supports provided to the individual will not need to be conducted. If, on the other hand, the individual is not experiencing positive outcomes, a deeper review of the way his or her protections and supports were developed, implemented, and monitored will occur. In order to assist in ensuring positive outcomes are sustainable over time, a human services quality improvement system needs to ensure that solid protections, supports, and services are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

In addition, the parties agreed upon a set of five broad outcomes for individuals to help guide and evaluate services and supports. These are called Domains and are included in this report.

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of

the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

In order to assess the facility's compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities:

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
d. **Observations –** While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews –** The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Scoring –** The report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. The parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews. Therefore, none of the figures in this report should be construed as a statement regarding the Facility's compliance with the Settlement Agreement.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
d. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
e. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Rio Grande State Center for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated. Some additional topics are highlighted below.

- Regarding document and records. The facility had a records system that included aspects that lived electronically, in a system called CWS, and aspects that lived on paper in the active record. This created many challenges for the facility, as well as for anyone trying to review documents because the rules set by facility policy were not always followed. During a meeting with various facility management staff while onsite, the director of records explained the facility's record system, which was that, except for the handful of documents that lived electronically, everything else should be in paper in the active record binders. But, even so, there were examples of where this wasn't the case, such as PBSPs that were discontinued and replaced by PSPs, but were still in the active record, with no PSP in the active record, and with the individual notebook containing both

the PBSP and PSP. Another example was that the IPNs in CWS were not used by all clinicians and that some departments kept a separate set of IPNs that did not contain all of the entries that ultimately appeared in CWS. The document management system at Rio Grande SC needs attention, much as it did at the time of the last review nine months ago.

Although Facility staff were responsive to the Monitoring Teams' requests to correct document issues, the Monitors remain unsure that the Facility provided all relevant documents. As a result, the Monitors' findings are based on the documents provided and might not reflect all protections, supports, and services provided to individuals reviewed at Rio Grande State Center

  - Regarding the completion of actions all the way to resolution. There were many open items across the facility. For example, there were close to 40 items listed in the IMRT minutes that had not been followed to completion, some going back many months. This was similar to the length of the list managed by the human rights officer and human rights committee. Also, restraint documents remained pending for many individuals, some for many months. Similar types of unfinished business were found across the facility. Some of these were system issues, some were about single issues for single individuals, and some only required some sort of review by QA. It was good to see that Rio Grande SC kept these lists, but on the other hand, it clearly demonstrated the need for completion.

  - Regarding employment, work, and day programs. The employment options on campus were extremely limited: shredding and making gravel. There were zero opportunities for off campus employment. The new ISP process, however, will likely set the occasion for improvement because IDTs will likely call for more individualized employment options for individuals. The onsite day activity program courtyard area had the potential for the creation of more meaningful and engaging activities, but much more work was needed.

- Rio Grande SC was operating under extremely high direct support professional turnover. It was reported to the Monitoring Team that it was 80%. Facility management was well aware of this problem and had some plans in development to address this.

Status of Compliance with the Settlement Agreement

Domain #1: The State will make reasonable efforts to ensure that individuals in the Target Population are safe and free from harm through effective incident management, risk management, restraint usage and oversight, and quality improvement systems.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
			Individuals:									
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	58% 7/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (July 2015 through March 2016) were reviewed. Overall, the use of crisis intervention restraint remained generally low at Rio Grande SC, and at a census-adjusted rate that was third lowest in the state, resulting in criterion being met for this data item. That being said, the use of crisis intervention restraint was higher than at the time of the last review and the Monitoring Team's examination of data for April 2016 and the first half of May 2016 did not show any descending trends. This should be closely monitored by the facility, perhaps by the quality assurance department and by the QAQI Council (called the SA-PIC at Rio Grande SC).

The use of physical crisis intervention restraint showed a decreasing trend across the nine-month period. The duration of physical crisis intervention restraints was similar to most other SSLCs. The use of mechanical crisis intervention restraints remained at zero.

A large percentage of the crisis intervention restraints were chemical crisis intervention restraints, that is, 50%. This was considerably higher than all of the other SSLCs (range 0%-29%, average of 9%). Furthermore, there was a disregard for pre-restraint consultation with behavioral health services staff prior to the administration of chemical crisis intervention restraint, as required. This may be more of an issue during "off hours," that is, after 5:00 pm and before 8:00 am, and on weekends and holidays, which is when many of the chemical restraints were ordered and implemented. The regular psychiatrist worked very well and in collaboration with behavioral health services.

The number of injuries that occurred during restraint was low and the one occurrence was not serious. The number of different individuals for whom crisis intervention restraint was used had increased over the nine-month period. Data for April 2016 and the first half of May 2016 showed numbers higher than any of the previous nine months. The number of individuals who used protective mechanical restraint for self-injurious behavior was at zero.

The use of chemical or non-chemical restraint for medical procedures was increasing over the nine-month period. The use of chemical or non-chemical restraint for dental procedures was increasing and low, respectively.

Thus, state and facility data showed low usage and/or decreases in seven of these 12 facility-wide measures (i.e., overall use of crisis intervention restraint, use of physical and mechanical crisis intervention restraint, duration of physical crisis intervention restraints, injuries during restraint, use of protective mechanical restraint, use of non-chemical restraints dental procedures).

2. Three of the individuals reviewed by the Monitoring Team were subject to restraint. One received crisis intervention physical restraints (Individual #50), and all three received crisis intervention chemical restraint (Individual #45, Individual #50, Individual #140). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for all three. The other six individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period or during the previous nine-month period.

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.

#	Indicator	Overall Score	Individuals:								
			45	50	140						
3	There was no evidence of prone restraint used.	100% 6/6	2/2	2/2	2/2						
4	The restraint was a method approved in facility policy.	100% 6/6	2/2	2/2	2/2						
5	The individual posed an immediate and serious risk of harm to him/herself or others.	83% 5/6	1/2	2/2	2/2						
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	0% 0/1	N/A	0/1	N/A						
7	There was no injury to the individual as a result of implementation of the restraint.	83% 5/6	2/2	1/2	2/2						
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	83% 5/6	1/2	1/2	2/2						
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	N/A	N/A	N/A	N/A						
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	0% 0/5	0/2	0/1	0/2						
11	The restraint was not in contradiction to the ISP, PBSP, or medical	100%	2/2	2/2	2/2						

	orders.	6/6									

Comments:
The Monitoring Team chose to review six restraint incidents that occurred for three different individuals (Individual #45, Individual #50, Individual #140). Of these, one was a crisis intervention physical restraint, and five were crisis intervention chemical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

5. For Individual #45 10/22/15 6:55 am, the post restraint ISPA noted that staff present during the chemical restraint reported that at the time that the actual shot was given, he was not combative or dangerous.

6. One restraint was a physical restraint, Individual #50 1/28/16 7:30 pm. The restraint checklist showed code Y (release completed) rather than code S (immediately because no longer a danger).

7. A non-serious injury was noted for the restraint for Individual #50 1/28/16 7:30 pm.

8. For Individual #45 10/22/15 6:55 am, as noted above, the chemical restraint (shot) was given when he was not combative or dangerous. The most logical conclusion is that the shot was given either as punishment for a behavioral outburst that had since subsided, to prevent a future behavioral outburst, or because once ordered, the administering staff did not question the physician or the physician refused to remove the order. For Individual #140 11/6/15 4:20 am, the restraint checklist documented a lot of pre-restraint actions; this was good to see.

9. Because criterion for indicator #2 was met for all three individuals, this indicator was not scored for them.

10. For the five chemical restraints, the facility did not provide the required form documenting pre-restraint consultation with a psychologist or behavioral health services staff. In fact, the face-to-face assessment form was scored N/A in response to the query on whether pre-restraint psychologist/behavioral health consultation occurred.

11. All individuals had the proper restraint contraindication information in their IRRF section of their ISP.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.

			Individuals:								
#	Indicator	Overall Score	45	50	140						
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 7/7	3/3	1/1	3/3						

Comments:
13. Staff who worked with all three individuals correctly answered the Monitoring Team's questions. Some staff provided additional

information, such as the requirement for a restraint monitor to be present.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.												
			Individuals:									
#	Indicator	Overall Score	45	50	140							
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	0% 0/6	0/2	0/2	0/2							
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A							
Comments: 13. Appropriate restraint monitors were not present, not present within the required 15 minutes, or was the same staff who administered the chemical restraint.												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.												
			Individuals:									
#	Indicator	Overall Score	45	50	140							
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	67% 4/6	1/2	1/2	2/2							
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	83% 5/6	1/2	2/2	2/2							
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	33% 2/6	0/2	1/2	1/2							

Comments: The crisis intervention restraints reviewed included those for: Individual #45 on 10/22/15 at 6:55 a.m., and 12/19/15 at 1:19 p.m.; Individual #50 on 10/22/15 at 9:05 p.m., and 1/28/16 at 7:30 p.m.; and Individual #140 on 10/31/15 at 10:00 p.m., and 11/6/15 at 4:20 a.m.

a. On a positive note, nursing staff initiated monitoring within 30 minutes for all six restraints. Problems noted included:

- For Individual #45's restraint on 12/19/15 at 1:19 p.m., mental status was documented as "awake and alert" or awake and oriented times three. Nursing staff needed to document more information related to the individual's behaviors to describe mental status.

- For Individual #50's restraint on 10/22/15 at 9:05 p.m., some vital signs were marked as "N/A."

b. For Individual #45's restraint on 10/22/15 at 6:55 a.m., the nursing IPNs did not include a status regarding any potential injury.

c. The nursing IPNs for the following restraints did not provide the rational for giving the chemical restraint and/or information regarding their effectiveness: Individual #45 on 10/22/15 at 6:55 a.m., and 12/19/15 at 1:19 p.m.; and Individual #140 on 11/6/15 at 4:20 a.m.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
			Individuals:								
#	Indicator	Overall Score	45	50	140						
15	Restraint was documented in compliance with Appendix A.	83% 5/6	1/2	2/2	2/2						

Comments:
15. The documentation for Individual #45 10/22/15 6:55 am had conflicting information on the restraint checklist and face-to-face assessment form.

Restraint documentation was not completed in a timely manner. Many restraint forms remained "pending," that is, incomplete for many months after the restraint.

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
			Individuals:								
#	Indicator	Overall Score	45	50	140						
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	0% 0/6	0/2	0/2	0/2						
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/6	0/2	0/2	0/2						

Comments:
16. For these restraints, the face-to-face form did not include dated signatures showing behavioral health services director review or unit director (ICF director or home manager at Rio Grande SC) review, thus, there was no evidence that consequences and circumstances were assessed. For some of the restraints, an ISPA was held within three days, which was good to see, but proper completion of the face-to-face form, including dated signatures, is necessary to meet criterion with this indicator. For Individual #140 10/31/15 10:00 pm, a face-to-face form was not completed.

17. For these restraints, the ISPAs included recommendations. Implementation of these recommendations could not be determined

and while onsite, the facility told the Monitoring Team that there was no evidence of implementation.

Abuse, Neglect, and Incident Management

Rio Grande SC met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)

#	Indicator	Overall Score	Individuals: 92	65	45	50	140	133	150	128	123
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/5	N/A	N/A	0/2	0/1	0/2	N/A	N/A	N/A	N/A
48	Multiple medications were not used during chemical restraint.	0% 0/5	N/A	N/A	0/2	0/1	0/2	N/A	N/A	N/A	N/A
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/5	N/A	N/A	0/2	0/1	0/2	N/A	N/A	N/A	N/A

Comments:

47. These indicators applied to a chemical restraints for Individual #45, Individual #50, and Individual #140. None of the examples reviewed had the form Administration of Chemical Restraint: Consult and Review completed. In the cases of Individual #45 (two examples) and Individual #50 (one example), the psychiatry portion of the document was blank. In the case of Individual #140 (two examples), the document request indicated this form was "not applicable."

48. In four examples, two medications were utilized. In one example, regarding Individual #140, three medications were utilized. This is concerning given the risk of side effects and over sedation with combination of, or "stacking," of psychotropic medications. Additional information received following the monitoring visit included documentation of stat orders for emergency chemical restraint. Review of this list revealed the use of three medications on a stat basis for one individual (Individual #36) who was not chosen to be fully reviewed by the Monitoring Team. Furthermore, a review of once orders revealed that Individual #36 had orders for three intramuscular medications (Haldol, Ativan, Benadryl) concurrently on four occasions (twice on 3/24/16, twice on 4/11/16). It was not possible to determine if the medications were administered.

49. Psychiatric clinical documentation was reviewed. None of the five examples included documentation from psychiatry in the period

of time immediately following (e.g., one week) following the event.

Pre-Treatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/2	0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
Comments: a. The Facility did not have a policy that included dental criteria for selection of individuals for TIVA. In addition, the Facility did not have a protocol related to pre-operative assessments for individuals who were to have dental treatment completed under TIVA/general anesthesia. Thus, there was no process to ensure that individuals had an adequate pre-operative evaluation by the PCPs or other specialists. For these two individuals, because of the lack of criteria for pre-operative evaluation, the Monitoring Team could not confirm that proper procedures were followed prior to TIVA. Individual #63 also did not have a specific informed consent signed for TIVA. b. For Individual #140 and Individual #63, a note defined procedures and assessment completed. However, the PCP had not determined medication and dosage range with the input of the interdisciplinary committee/group, and informed consent was not present/submitted. For Individual #140, no restraint list was submitted. Individual #63 had parenteral sedation and monitoring once she returned, but there was no monitoring documented during the time she was off campus, which was problematic given that she had an injection of pre-treatment sedation.											

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/5	0/2	N/A	N/A	0/1	N/A	N/A	0/2	N/A	N/A
Comments: a. Medical pre-treatment sedation was used for the following: Individual #140 – urology on 11/19/15, and renal on 12/31/15; Individual #79 – cardiology on 11/30/15; and Individual #85 – CT of abdomen on 1/15/16, and DEXA scan on 12/28/15.											

Facility staff reported that the IDT discussed sedation during ISP/ISPA meetings. However, there was no interdisciplinary committee to discuss this, and Pharmacy Department staff and PCPs were usually not noted to attend ISPAs. As a result, documentation was not available to confirm that with the input of the interdisciplinary committee/group, the PCP determined medication and dosage range. In addition, the Facility did not submit evidence of informed consent (i.e., the response to the Monitoring Team's document request stated "not applicable"). For the three individuals who received parenteral pre-treatment sedation, vital signs were documented both prior to and after the procedure. However, there was no evidence that the appropriate monitoring, for individuals who received parenteral sedation, was completed during the period that the individuals were away from the facility. The individual (i.e., Individual #79) who received a single dose of oral medication had appropriate documentation of vital signs.

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.

#	Indicator	Overall Score	Individuals:								
			45	140	50						
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/3	0/1	0/1	0/1						
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	67% 2/3	1/1	1/1	0/1						
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/1	N/A	0/1	N/A						
4	Action plans were implemented.	0% 0/1	N/A	0/1	N/A						
5	If implemented, progress was monitored.	0% 0/1	N/A	0/1	N/A						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/1	N/A	0/1	N/A						

Comments:
1. Three individuals received PTCR. Individual #45's PTCR usage and effectiveness were discussed in his nursing notes, however, informed consent from the LAR or facility director, potential risks of PTCR, and supports/interventions that could be provided were not indicated. Alternative interventions were suggested in Individual #140's ISPA, however, PTCR effectiveness, behaviors observed during

the procedure, the potential risks of PTCR, and informed consent were not found in her ISP or ISPAs. Individual #50's ISPA indicated that several teeth were extracted and PTCR was used during the procedure. No other info concerning the PTS was found in Individual #50's ISP/ISPAs. 2. Individual #140 had a plan to reduce future PTCR discussed in her ISPA. Individual #45's IDT determined that a plan would be counter-therapeutic. 3. Individual #140's plan did not include sufficient detail to determine if it was based upon the underlying hypothesized cause, and was not included in an ISPA action plan. 4-6. There was no evidence that Individual #140's plan was implemented, monitored, or modified.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
			Individuals:								
#	Indicator	Overall Score	5	146	112						
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	0% 0/3	0/1	0/1	0/1						
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	100% 3/3	1/1	1/1	1/1						
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	100% 3/3	1/1	1/1	1/1						
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	100% 3/3	1/1	1/1	1/1						
e.	Recommendations are followed through to closure.	0% 0/3	0/1	0/1	0/1						
Comments: a. Since the last review, three individuals died. The Monitoring Team reviewed all three deaths. Causes of death were listed as: • Individual #5 at the age of 47 died of sepsis;											

- Individual #146 at the age of 35 died of congestive heart failure, and Esenmenger Syndrome; and
- Individual #112 at the age of 65 died of Chronic relapsing Clostridium Difficile (C. Diff) Colitis, and adult failure to thrive related to profound mental retardation.

None of the mortality reviews were completed on time and extensions were granted for all of them with various explanations for the extension, including autopsy not available, Investigative Officer's report not complete, etc. These were not valid reasons to not complete at least a preliminary review. The Facility should conduct a preliminary review to address any immediate concerns, and the report can be finalized when all data is available.

b. through d. An investigative officer (i.e., a MD working at the Facility, but not in the ICF) completed reviews for all deaths. These reviews surfaced a number of issues related to medical care. Questions were surfaced related to a lack of specialty consultation, consults that appeared to be ordered but were never completed, and failure to pursue known alternative treatment options when current therapy failed. More importantly, the question of "how can we prevent similar circumstances in the future?" surfaced. A number of these issues were addressed through corrective actions that were reported as closed. These reports added value to the mortality system; however, the physician reviewer is not external to the Facility, which has one Medical Director for all divisions. Texas A&M Health Science Center completed two mortality reviews for deaths that occurred, but were not covered by this review. The quality of these reviews, therefore, was not assessed, but this might provide an option for an external review of deaths.

The reports the Quality Assurance (QA) Nurse generated for the Mortality Reviews were comprehensive and exceptional in relation to the identification of problems and the development of associated recommendations. In keeping with the concept of a mortality review, the QA Nurse reviewed a multitude of systems that may not have had any bearing on the outcome of the cases in order to proactively identify any problematic issues so that the facility can address these areas in the hopes to avert any future negative outcomes. In sum, Rio Grande's QA Nurse has continued to produce quality reviews of the mortalities and is supported by the Center's QA Director.

e. The recommendations generally were not written in a way that ensured that Facility practice had improved. For example, a recommendation that read: "Staff to be trained on who to contact for the initiation of a work order to repair the scales" resulted in the provision of an in-service training session, and the recalibration of scales on 1/21/16. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required closure to include monitoring to determine whether or not scales were recalibrated regularly. Moreover, the lack of timely recognition, analysis, and implementation of specific interventions related to weight were noted for a number of individuals in the sample. IDTs were not timely identifying weight loss/gain that was occurring over a period of time and not timely implementing strategies such as obtaining weights more frequently than monthly or analyzing the weight issue using the appropriate data, such as identifying the actual calorie intake when additional food was being obtained outside of the prescribed diets.

Similarly, the recommendation that read: "Retraining of Nursing staff and IDT on comprehensiveness of assessments, documentation of refusals, delineation of assessments, IHCP, risk ratings" was considered closed on 3/3/16. As the results in this report show, the outcome of improved assessments, IHCPs, and risk ratings was not achieved through the in-service training provided on nursing assessments, vague documentation, and medication administration documentation.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	ADRs are reported immediately.	0% 0/2	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2		0/1		0/1					
c.	Clinical follow-up action is taken, as necessary, with the individual.	0% 0/2		0/1		0/1					
d.	Reportable ADRs are sent to MedWatch.	N/A		N/A		N/A					

Comments: a. For Individual #50 and Individual #79, clinicians documented in the records that an ADR occurred, but no Suspected ADR form was submitted. Discontinuation of a drug due to suspicion of an ADR should require completion of the proper ADR Reporting Form. More specifically:

- For Individual #50, on 11/24/15, the Mobic was stopped due to paresthesias. A probability scale should have been completed as well as the timelines for starting an upward titration of drugs. Collecting this data might have pointed to the fact that drugs such as topirimate and INH are highly associated with paresthesias, to a far greater extent than Mobic. Pyridoxine is given with INH to prevent the development of peripheral neuropathy. The fact that the paresthesias resolved with the discontinuation of the Mobic does not necessarily implicate it as the cause of the paresthesias, because topirimate-related paresthesias usually resolve.
- For Individual #79, IPNs and nursing documentation reported that on 8/8/15, Coreg was discontinued due to an ADR (i.e., bullous skin eruption). There was no Suspected ADR form submitted. Per the Quarterly Drug Regimen Review (QDRR), this was determined not to be an ADR, but a subsequent QDRR (submitted after the initial document request) documented an allergy/sensitivity to Coreg.

b. through d. The Pharmacy and Therapeutics Committee or other body that has responsibility for oversight of the Facility's ADR reporting and monitoring system should conduct a review of all suspected ADRs. The probability of an ADR should then be determined using an ADR probability scale. However, the Pharmacy and Therapeutics Committee minutes for December 2015, documented no ADRs. There did appear to be discussion about revising the ADR form and training nursing staff. At the time of the Monitoring Team's review, it did not appear that the Facility had a functioning ADR reporting and monitoring system.

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but	0%

	no less than quarterly.	0/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. A DUE Report should clearly outline the reason the DUE is being completed, the objective of the study, sample size, methodology, data/data analysis, conclusion, and recommendations. The Pharmacy and Therapeutics Committee minutes should document presentation of the DUE, recommendations, and a plan of action to address the recommendations. The information the Facility submitted did not meet these criteria. More specifically:

- For November 2015, the Facility submitted Medical Staff Summaries that documented compliance (%) with indications for Lithium, addressing contraindications, monitoring compliance, and dose guidelines. However, there was no DUE Report that summarized the reason for completing the DUE, methodology, findings, data analysis and final results, as well as recommendations.
- For February 2016, the Facility submitted a clozapine policy, and Medical Staff Summaries that documented compliance (%) with indications, addressing contraindications, monitoring compliance, and dose guidelines. However, there was no DUE Report that summarized the reason for completing the DUE, methodology, findings, data analysis and final results, and recommendations. Clozapine is a highly regulated, high-risk medication. Monitoring its use is appropriate. However, the information submitted did not fit the format of an appropriately completed DUE.

b. There should be documentation regarding closure of the recommendations. Based on documentation submitted, it was unclear whether or not formal DUEs were completed and/or whether or not recommendations were needed and/or made. For example, the Facility submitted minutes for the 12/16/15 Pharmacy and Therapeutics Committee Meeting. The recommendations, if any, from the review of Lithium in November 2015 were not documented, and there was no follow-up for recommendations from previous medication reviews. On 12/16/15, this meeting was conducted, and on 4/6/16, the committee chair signed the minutes.

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	0/6	1/6	0/6	1/6	0/6	0/6			
2	The personal goals are measurable.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #92, Individual #50, Individual #140, Individual #123, Individual #79, Individual #63). The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Rio Grande SC campus.

1. The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator and the QIDP educator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, they will need to provide a lot of feedback to the QIDPs and to other team members.

Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

Overall, outcomes for the ISPs remained very broadly stated and general in nature and/or were very limited in scope and none had individualized goals in all areas. There was some incremental improvement in the individualization of individuals' living options goals that were not the commonly used generic goal to live in the most integrated setting consistent with preferences, strengths, and needs.

While improved in terms of individualization, it was still not always clear these goals reflected individuals' desired personal outcomes or were aspirational in nature. Individual #50 also had a personal goal to learn to read and speak English, which was practical, personally meaningful and aspirational.

There were other positive signs that IDTs were beginning to formulate meaningful goals for individuals. The Monitoring Team was able to also review an ISP for Individual #140 completed after the document request, however, and was impressed with the set of personal goals contained therein. While this ISP were not scored for the purposes of this review, it is likely they would have received positive ratings. Each of the goals were individualized, integrated preferences and strengths, and were aspirational in nature. These goals included:

- To live in a group home near her family in Brownsville;
- To work in a western wear clothing store, which integrated her interests in country-western things and clothes shopping, with action plans that included a DARS referral, a SAMS objective, and obtaining a Texas ID;
- To volunteer at a local zoo, because she loved animals. This was also envisioned as an opportunity to make friends in the community;
- To learn to track hurricanes, a pastime she was very interested in; and
- To eat a hamburger. On its face, this didn't sound particularly aspirational, but in fact it was. She loved hamburgers, but had a chopped diet, so the IDT planned to teach her to chop her own food. (The team may be encouraged to further address dining behaviors that necessitate the chopped diet, but this was a good first step.)

The Monitoring Team also attended onsite ISP annual meetings for Individual #123 and Individual #128 and an ISP preparation meeting for Individual #92. The discussion toward defining personal goals in the meetings for Individual #123 and Individual #92 was observed to be improved from previous visits, in that the IDTs clearly examined individual preferences more closely and proposed individualized goals. The Monitoring Team remained concerned, however, that the staff facilitating the meetings tended to shut off discussion in a manner that constrained staff from fully exploring sensitive yet important subjects. One such example of this phenomenon occurred when Individual #92's IDT began a discussion of her interest in a friendship with a male peer.

2. Overall, personal goals did not meet criteria for indicator 1 for the set of ISPs being scored, therefore, there was no basis for assessing measurability.

3. Overall, for the personal goals for these ISPs, reliable and valid data for ISP action plans were seldom available due to problems, such as inconsistent implementation and lack of clear implementation and documentation methodologies.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.

#	Indicator	Overall Score	Individuals:								
			92	50	140	123	79	63			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: Once Rio Grande SC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

8. Personal goals did not meet criteria for indicator 1 in the ISPs as indicated above. The action plan for Individual #50's goal for learning English tended to be far less aspirational than the goal itself, to the point that it would take many, many years to achieve at that rate. The only action plan toward this goal was to identify restroom signs in the community. Similarly, the action plans for Individual #140's new ISP goals could have been considerable more robust. Her living options goal to live in a group home in Brownsville and near family had one action plan, which was for the psychiatrist to continue to follow her progress and adjust medication as needed in an attempt to stabilize her. While this action step was likely one critical factor in her eventual move, other action plans could have addressed her awareness in the meantime. If the IDT decided to defer any other steps, then it would have been appropriate to have set measurable objectives that would have indicated when additional action steps could be considered. As it stands, there was no action projected for the next year, but to monitor and adjust medications and no measurable criteria to indicate when she could be considered stabilized.

9. Overall, preferences and opportunities for choice were not well-integrated in the individuals' ISPs. PSIs did not consistently provide sufficient information and/or analysis that may have made them useful for integrating preferences. Three of six individuals did not have a current PSI at the time of their ISP annual meeting, in any event. On a positive note, as described above, there was evidence that IDTs were beginning to be more creative about using preferences to develop personal goals.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the individuals. None of the individuals had action plans related to informed decision-making.

11. Overall, action plans did not assertively promote enhanced independence for any of the individuals. Examples included:
- Functional Skills Assessments for all six individuals had no analysis, summary, or recommendations that could have guided the IDT toward action plans to promote independence.
- For Individual #79, the FSA tool data indicated many additional opportunities for independence. Examples included that she could answer a phone correctly and independently, but required manipulation to dial, and that she used sidewalks, but needed physical prompts to use crosswalks. Neither were considered by the IDT.
- For Individual #63, FSA tool data also indicated many additional opportunities for independence that were not considered, such as used sidewalks and stopped to look for oncoming vehicles, but needed verbal cues to wait for the vehicle to safely pass.
- For Individual #92, there had been no focus during the past year on enhancing her communication skills. A positive was that the IDT did begin to consider this need at her ISP preparation meeting observed on site.

12. IDTs did not integrate strategies to minimize risks in ISP action plans. Examples included:
- The Monitoring Team was concerned that risks of falls and other injuries were not proactively addressed by Individual #63's IDT.
- IHCP action plans in this area were broad, generalized, and not preventative in nature.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated. In addition to the examples provided in #11 and #12 above, others included individual's behavioral health needs not being assertively addressed due to delays in completion of behavioral health assessment and implementation of PBSPs, and the lack of training provided to staff in this area. This was evidenced by not only the lack of training documentation, but by the lack of staff knowledge upon interview.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community participation that would have promoted any meaningful integration for any individual.

15. Day program and work opportunities were extremely limited, with shredding and bagging rocks the only vocational activities offered regardless of preferences, strengths, and needs. None of the six ISPs supported work in an integrated setting. On a very positive note, however, the new ISP for Individual #140 had goals for both integrated work and integrated volunteer activity in the community.

16. None of the six had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration,

and intensity throughout the day to meet personal goals and needs.

17. Barriers to various outcomes were not consistently identified and addressed in the ISP, including the following:
- Living options barriers were frequently not addressed with action plans.
- The IDT had identified employment barriers for Individual #50, but did not meet to develop action plans to address these. Instead, Individual #50 remained in the home most of the day.

18. For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAP instructions for teaching, data collection and progression were unclear. IHCPs were often broad and generalized without specific and individualized criteria.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	50% 3/6	1/1	1/1	0/1	0/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified.	50% 1/2	N/A	N/A	N/A	1/1	N/A	N/A			
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to	0%	N/A	N/A	N/A	N/A	N/A	N/A			

	address/overcome the identified obstacles.	0/1									
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Two of six ISPs (Individual #50, Individual #123) included a description of the individual's preference and how that was determined. The others' preferences were unknown.

20. For Individual #123, whose ISP was observed onsite, the IDT had not engaged his mother in sufficient discussion to know whether it was possible for him the return to her home, as he wished, rather than move to a group home near her home, as the IDT proposed. The IDT had also not engaged Individual #123 or his mother in a discussion of the other alternatives, which was a clear need based on his expressed wish to live at home at the time of the prior ISP. At Individual #128's annual ISP meeting, Individual #128's living option preferences were not discussed.

21. None of six ISPs fully included the opinions and recommendation of the IDT's staff members. The opinions of key staff members were sometimes not available or discrepancies among these opinions were not examined in a manner that would justify the overall decision.

22. Six of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR.

23. None of the individuals had a thorough examination of living options based upon their preferences, needs and strengths. Examples included:

- For Individual #140, there was no discussion of why she changed her mind about transition to a group home in 2013 as a means of identifying potential barriers and developing responsive APs.
- For Individual #50, there was no discussion of possible living options and the barriers presented by lack of citizenship.

24. Three of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed.

25. Individual #123 was referred at the annual ISP meeting observed. At Individual #128's annual ISP meeting, obstacles to referral were not discussed or identified.

26. There were no action plans to address LAR choice for the two individuals (Individual #140, Individual #123) with that identified barrier. Only Individual #63 had a community living options action plan. It was not measurable and the action plan did not incorporate the IDT discussion about her visiting homes of peers who have moved.

28. See above.

29. No individuals had been referred for the ISPs reviewed. (For Individual #123, it was noted he was referred at the time of the observed ISP.)

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
30	The ISP was revised at least annually.	100% 5/5	1/1	N/A	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	50% 3/6	0/1	1/1	1/1	1/1	0/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
30-31. ISPs were developed on a timely basis.

32. Action plans were implemented on a timely basis for no individuals. Examples included:
- For Individual #63, the SAMS and money management action plans were not implemented within 30 days; the latter was not implemented for the period November 2015-January 2016.
- Individual #140's goals for balance and parallel bars not implemented timely.
- For Individual #50, action plans were not being implemented. He was not attending vocational, but no work alternative had been developed.

33. Three of six individuals attended their ISP meetings. For two individuals (Individual #79, Individual #63,) the ISP documented partial attendance without any explanation or evidence the individual had participated in the planning process in any meaningful way.

34. Individual #140 appeared to have an appropriately constituted IDT at her ISP annual planning meeting, however, the QIDP and DSPs were not knowledgeable about aspects of her programming, such as the PBSP. Other individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:
- There was no SLP at Individual #92's ISP annual meeting, despite having needs in this area.

• For Individual #50, Individual #123, and Individual #79, there was no DSP in attendance.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	40% 2/5	0/1	N/A	1/1	1/1	0/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for one of five individuals (not including Individual #50 who was a new admission.) Individual #79 and Individual #63 had new format ISPs and should have had an ISP preparation meeting, but did not. Individual #92's ISP preparation did not have documentation that assessment requirements were considered.

36. IDTs did not always arrange for and obtain needed, relevant assessments prior to the IDT meeting. For example, Individual #140, Individual #123, and Individual #79 had behavioral health assessments that were outdated. No one had a Functional Skills Assessment that included any summary or recommendations.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
37. IDTs did meet frequently to respond to events, behavioral incidents, and medical issues, but did not review progress or revise supports and services as needed. This was attributable in part to the lack of consistent and timely QIDP monthly review, which should alert not only the QIDP, but the rest of the IDT to the status of supports and services. In another example, after Individual #45 returned from a failed placement in the community, his ISP was not reviewed or revised.

38. Three of six individuals had no QIDP monthly reviews since November 2015, and the reviews for the remaining three were

completed sporadically. At the time of the last onsite visit, the Monitoring Team found the IDT process was not competent overall to adequately address the needs of individuals living at the facility and ensure they received required monitoring/review and revision of treatments, services, and supports. Concerns included:

- the absence of well thought out organizational IDT processes and structures to provide clear expectations and timelines for team members without being so inflexible as to stymie brainstorming and creative problem solving;
- the lack of availability and reliability of data needed for assessment and treatment decisions;
- a lack of timeliness in general or a sense of urgency when needed;
- a lack of free-flowing communication among team members; and
- a lack of willingness on the part of individual team members to assume personal responsibility for reaching resolution on difficult issues.

There had been little progress in this regard and various IDT members indicated during this onsite visit they felt constrained and/or their input largely ignored in IDT proceedings. The Monitoring Team also observed this phenomenon in some of the meetings attended during the onsite.

Along the same vein, the role of the designated QIDPs in providing leadership for the IDTs was unclear. During team meetings, the QIDPs sat at a separate table and acted as scribes, severely limiting their active involvement in team discussion, and perhaps their status as the go-to team leader. It is impossible to take accurate notes (which is very important for ISP meetings) and to be fully engaged in the discussion and making thoughtful contributions.

The Monitoring Team was also very concerned about the lack of knowledge demonstrated by one QIDP about at least one individual served. The QIDP was unable to describe the individual and indicated paperwork and other duties made it difficult to spend any time interacting with or observing individuals. It was not clear how much of this could be attributed to over-work, since another QIDP was considerably better informed. Nevertheless, steps should be taken to ensure each QIDP has sufficient familiarity to adequately address each individual's needs.

Outcome 1 – Individuals at-risk conditions are properly identified.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual's risk rating is accurate.	22% 4/18	0/2	0/2	1/2	0/2	1/2	0/2	1/2	0/2	1/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	28% 5/18	1/2	0/2	0/2	1/2	1/2	1/2	1/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #140 – falls, and weight; Individual #50 – weight, and other: substance abuse and smoking; Individual #138 – dental, and polypharmacy/side effects; Individual #79 – fractures, and constipation/bowel obstruction; Individual #63 – dental, and falls; Individual #115 – weight, and

fractures; Individual #85 – falls, and other: pain related to past spinal surgery; Individual #29 – constipation/bowel obstruction, and falls; and Individual #97 – dental, and behavioral health).

a. It was positive that for most of the risks reviewed, IDTs had used the risk guidelines in determining risk levels (i.e., the exceptions were weight for Individual #140, and falls for Individual #29). The IDTs that effectively used supporting clinical data when determining a risk level were those for Individual #138 – dental, Individual #63 – dental, Individual #85 – falls, and Individual #97 – dental.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression, and to monitoring for side effects resulting from treatment with psychotropic medications. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

While all individuals had data monitoring occurring for problematic behaviors (e.g., physical aggression, self-injurious behavior), there were examples where symptoms associated with a psychiatric diagnosis were being objectively monitored using the DASH II (Diagnostic Assessment for the Severely Handicapped). This was good to see, however, this scale is based on DSM-III-R diagnostic criteria, and is most useful when making the initial diagnosis. Most of the examples where this scale was utilized simply provided

scores for the most recent period. When scores were graphed over time, it was not possible to determine what symptoms were elevated because the data from the instrument were clumped into a single numerical result. It was not possible to determine what the symptoms were at the time of the assessment. Furthermore, when data were presented, graphs were generally stale, anywhere from two to four months old. In order to make data driven decisions regarding psychotropic medication efficacy, up to date, contemporaneous data are necessary.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.												
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
12	The individual has a CPE.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
13	CPE is formatted as per Appendix B	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
14	CPE content is comprehensive.	67% 6/9	1/1	1/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	67% 2/3	0/1	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

13. The CPEs for Individual #65 and Individual #150 were not formatted as per Appendix B. These evaluations, dated 7/22/13 and 12/10/14 respectively, included additional section headers and the information was presented out of order.

14. The Monitoring Team looks for 14 components in the CPE. For the three evaluations that did not meet criteria for this indicator, two lacked sufficient laboratory examinations. The third evaluation was lacking sufficient information in four components.

Overall, the bio-psycho-social component of all evaluations was thorough. This was good to see.

15. For the three individuals admitted since 1/1/14, two had psychiatric evaluations that were completed within 30 days. The third individual, Individual #92, was admitted to the facility 9/15/14 and the initial psychiatric evaluation was completed on 12/5/14.

16. Criterion was met for six individuals. There was a need for improvement with regard to the consistency of diagnoses in the others.

For example, in the case of Individual #65, psychiatry documented a diagnosis of an alcohol use disorder. This diagnosis was not included in behavioral health documents.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
17	Status and treatment document was updated within past 12 months.	0% 0/6	0/1	N/A	0/1	N/A	0/1	0/1	0/1	N/A	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/6	0/1	N/A	0/1	N/A	0/1	0/1	0/1	N/A	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	78% 7/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17-18. Problems with obtaining the required documents hampered the Monitoring Team's evaluation of these indicators. Some documents were obtained while onsite, some were marked as not applicable, and others were not located. Based on the available documents, the facility psychiatry clinic was delinquent with regard to completion of the annual psychiatric evaluations. None of the six individuals who were due for an annual evaluation had one completed within the required time frame. The Monitoring Team scores 16 aspects of the annual evaluation document, however, as none had been completed within the required annual time frame, none were scored.

21. There was a need for improvement with regard to the documentation of the ISP discussion to include the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective and the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication in addition to the benefits. The Monitoring Team looks for the above noted aspects of psychiatry participation.

In the ISP for Individual #133, there was improved documentation regarding the rationale for determining that the proposed interventions represented the least intrusive and most positive interventions as well as a discussion of the risk/benefit analysis of the prescribed psychotropic medication. This was good to see.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	50% 1/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	1/1

Comments:
22. Two individuals, Individual #123 and Individual #133, had a PSP in place. The Monitoring Team scores four aspects of the PSP. The PSP for Individual #123 met criteria. In the PSP for Individual #133, there was no focus on data collection regarding symptoms of this individual's psychiatric diagnosis, but rather a focus on collecting data regarding behavioral challenges.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
32	HRC review was obtained prior to implementation and annually.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1

Comments:
29. The facility consent forms included a limited listing of potential medication side effects. Older consent forms included documentation that additional medication information was provided to the individual or to the LAR providing consent for treatment.

30-31. The risk versus benefit discussion was not included in the consent form. Alternate and non-pharmacological interventions were noted as "Behavior Support Plan" and, therefore, did not meet criterion.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 12/12	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
3	The psychological/behavioral goals/objectives are measurable.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
4	The goals/objectives were based upon the individual's assessments.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A

Comments:

1. Of the 16 individuals reviewed by both Monitoring Teams, 12 required a PBSP (seven of nine individuals reviewed by the behavioral health Monitoring Team and five individuals reviewed by the physical health Monitoring Team). All 12 of those individuals had PBSPs. Individual #133 and Individual #123 recently had PBSPs that were discontinued and replaced with a psychiatric support plan (PSP).

2-4. All individuals with a PBSP had measurable behavioral objectives, based upon the individual's assessments.

5. Individual #45 had recent interobserver agreement (IOA), but no data collection timeliness assessments. The remaining six individuals with PBSPs did not have IOA or data collection timeliness assessments in the last six months. In order to ensure that target and replacement behavior data are reliable, it is critical that all individuals with PBSPs have regular IOA and data collection timeliness measures.

Ensuring reliability of data should be a priority area for improvement for the Rio Grande SC behavioral health services department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
10	The individual has a current, and complete annual behavioral health update.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1
11	The functional assessment is current (within the past 12 months).	43% 3/7	0/1	1/1	0/1	1/1	0/1	N/A	0/1	1/1	N/A
12	The functional assessment is complete.	86% 6/7	1/1	1/1	1/1	1/1	1/1	N/A	0/1	1/1	N/A

Comments:
10. Individual #92 did not have an annual behavioral health assessment. Additionally, Individual #65, Individual #45, Individual #140, Individual #133, Individual #123, and Individual #150's annual behavioral health assessments were more than 12 months old.

11. Individual #65, Individual #50, and Individual #128 had current (written/revised in the last 12 months) functional assessments.

12. All of the functional assessments contained all of the necessary components and were generally of good quality. Individual #150's functional assessment, however, was rated incomplete because the direct assessment did not include any target behaviors or a rationale why target behaviors were not included.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	29% 2/7	1/1	0/1	0/1	0/1	0/1	N/A	0/1	1/1	N/A
14	The PBSP was current (within the past 12 months).	43% 3/7	0/1	1/1	0/1	1/1	0/1	N/A	0/1	1/1	N/A
15	The PBSP was complete, meeting all requirements for content and quality.	71% 5/7	1/1	0/1	1/1	0/1	1/1	N/A	1/1	1/1	N/A

Comments:
13. There was documentation that the PBSP was implemented within 14 days of attaining consents for Individual #92 and Individual #128.

14. Individual #65, Individual #50, and Individual #128 had current (written/revised in the last 12 months) PBSPs.

15. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. All seven PBSPs contained all

of these components, the Monitoring Team found the PBSPs to be generally of high quality. Individual #65 and Individual #50's PBSPs were rated as incomplete, however, because the replacement behaviors were not functional and there was no rationale provided why a functional replacement behavior was not practical or functional.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
Comments: 24-25. Individual #150 was referred, and received counseling services at the time of the onsite review. There was, however, no treatment plan to review.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	63% 5/8	0/1	N/A	0/1	1/1	1/1	0/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not Rated (NR)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	83% 15/18	2/2	2/2	2/2	2/2	1/2	2/2	2/2	0/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	NR									
Comments: a. Problems varied across the medical assessments. It was positive that as applicable to the individuals reviewed, all annual medical assessments described past medical histories, interval histories, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included pre-natal histories, social/smoking histories, allergies or severe side effects of medications, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include complete family history as available, childhood illnesses as available, and plans of care for each active medical problem, when appropriate. b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. The diagnoses for which sufficient clinical justification was not present were anemia for Individual #63, and chronic pulmonary heart disease, and Raynaud's Disease for Individual #29. c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	44% 8/18	0/2	0/2	1/2	2/2	1/2	0/2	2/2	2/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	NR									
Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #140 – other: anemia, and constipation/bowel obstruction; Individual #50 – diabetes, and cardiac disease; Individual #138 –											

constipation/bowel obstruction, and other: hypothyroidism; Individual #79 – cardiac disease, and osteoporosis; Individual #63 – circulatory, and other: anemia; Individual #115 – cardiac disease, and seizures; Individual #85 – cardiac disease, and constipation/bowel obstruction; Individual #29 – cardiac disease, and osteoporosis; and Individual #97 – respiratory compromise, and osteoporosis).

The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #138 – constipation/bowel obstruction; Individual #79 – cardiac disease, and osteoporosis; Individual #63 – circulatory; Individual #85 – cardiac disease, and constipation/bowel obstruction; and Individual #29 – cardiac disease, and osteoporosis.

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.

#	Indicator	Overall Score	Individuals: 140	50	138	79	63	115	85	29	97
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	50% 4/8	1/1	N/A	1/1	1/1	1/1	0/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. None of the individuals reviewed had dental summaries that a dentist had completed. This issue had not been resolved since the last review.

b. It was positive that one dental exam the Monitoring Team reviewed contained all of the necessary components (i.e., Individual #85, who was edentulous). On a positive note, all dental exams reviewed included, as applicable, a description of the individual's cooperation, an oral cancer screening, an oral hygiene rating completed prior to treatment, a description of sedation use, a description

of periodontal condition, caries risk, periodontal risk, specific treatment provided, the recall frequency, and a treatment plan. Most included information regarding last x-ray(s) and type of x-ray, including the date. However, the dentist(s) should focus on ensuring exams include, as applicable, periodontal charting, an odontogram (i.e., the black and white odontograms could not be interpreted, and the key only indicated normal pathology), and a summary of the number of teeth present/missing.

c. As noted above and in the last report, none of the individuals reviewed had dental summaries. Facility staff reported that dental summaries never had been completed. It is important that they be completed in that the State's annual dental summary template documents the overall oral health status of the individual and provides recommendations to the IDT for future dental care. It also provides information on necessary supports inclusive of oral hygiene. A dentist should complete the summaries. The State's template adds the odontogram. At Rio Grande State Center, odontograms were included in the annual dental exam, but black and white copies were submitted, which could not be interpreted.

Moving forward the Facility should focus on ensuring dental summaries are completed and include the following, as applicable:

- Recommendations related to the need for desensitization or other plan;
- The number of teeth present/missing;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of written oral hygiene instructions;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individuals have timely nursing assessments:										

	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	88% 7/8	1/1	N/A	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/15	0/2	0/2	0/2	0/1	0/2	0/1	0/1	0/2	0/2

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #140 – falls, and weight; Individual #50 – weight, and other: substance abuse and smoking; Individual #138 – dental, and polypharmacy/side effects; Individual #79 – fractures, and constipation/bowel obstruction; Individual #63 – dental, and falls; Individual #115 – weight, and fractures; Individual #85 – falls, and other: pain related to past spinal surgery; Individual #29 – constipation/bowel obstruction, and falls; and Individual #97 – dental, and behavioral health).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. Often, due to the lack of ongoing, proactive nursing assessments, it could not be determined when an individual experienced a change of status. In addition, when individuals experienced changes in status, nursing assessments were not completed in accordance with nursing protocols or current standards of practice.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Problems seen across most IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	67% 2/3	1/1	N/A	N/A	N/A	N/A	0/1	1/1	N/A	N/A

b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 2/3	1/1					0/1	1/1		
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 1/2	0/1					N/A	1/1		
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	33% 1/3	1/1					0/1	0/1		
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	N/A	N/A					N/A	N/A		
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/3	0/1					0/1	0/1		
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/2	N/A					0/1	0/1		
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2	0/1					N/A	0/1		

Comments: a. through d., and f. For the three individuals that should have been referred to the PNMT:

- Individual #140 had a qualifying hospitalization with discharge on 9/19/15, and referral to the PNMT on 9/23/15. She was in the hospital for a week, and presented initially with septic shock, hypotension, respiratory distress resulting in intubation, severe constipation (also described as fecal impaction), and hydronephrosis requiring nephrostomy tube placement to the left kidney. On 9/29/15, the PNMT conducted a review that resulted in recommendations, but, based on the documentation provided, the PNMT did not document a determination as to whether or not a comprehensive assessment was necessary. The meeting minutes indicated that the PNMT "voted" to place her on their caseload. On 11/3/15, the PNMT completed a comprehensive assessment.
- As documented in his IRRF, since his admission to Rio Grande State Center, Individual #115 had experienced significant weight loss, but there was no evidence submitted of referral to or review by the PNMT. In its response to the draft report, the State disputed this finding, and stated: "There is no evidence of review by PNMT and was [sic] not referred because the individual did not have a 'significant weight loss' as identified in the IRRF. He did experience a weight loss but not as identified by the IRRF. This is an error as there is no record of such weight loss. His weight record was reviewed and he remained within his BMI, as stated on the IRRF. Aside from the IRRF, there is no such weight in his record of 105 lbs. His current record has him fluctuating

between 117-120 lbs." These comments provide inaccurate information. According to the weight record that the Facility submitted (Document #TX-RG-1605-II.23 for this individual), his weight was 128.2 pounds in September 2015, 129 in October 2015, and 129.8 in November 2015. In the months leading up to his ISP meeting, he experienced significant weight loss. His weight dropped to 121.3 in December 2015, 120.4 in January 2016, and 117.4 in February 2016. Although he remained within his ideal body weight, because this was unplanned weight loss, and because it met the criteria included in the audit tool for Physical and Nutritional Management Supports (i.e., more than five percent weight loss in one month between November and December 2015), the PNMT should have at least reviewed him.

- On 2/17/16, Individual #85 was referred to the PNMT due to an unplanned weight loss of 5.2% in one month that supports were not effective at addressing, and on 2/23/16, the PNMT conducted a review. The Facility did not have an Occupational Therapist (OT) on staff until shortly before the Monitoring Team's onsite review. Individual #85 required an OT assessment to address positioning during mealtimes, but one was not completed.

e. For Individual #140's hospitalization in September 2015, the Facility submitted no evidence that an RN Hospitalization Review was completed.

h. Overall, the PNMT Comprehensive Assessments the Monitoring Team reviewed did not comprehensively address individuals' needs. Moving forward, the Facility should focus on developing quality comprehensive PNMT assessments that:

- Describe the presenting problem;
- Include discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Review the individual's behaviors related to the provision of PNM supports and services;
- Include discussion of medications that might be pertinent to the problem, and discussion of their relevance to PNM supports and services;
- Provide evidence of observation of the individual's supports at his/her program areas;
- Provide an assessment of current physical status;
- Include discussion as to whether existing supports were effective or appropriate;
- Identify the potential causes of the individual's physical and nutritional management problems;
- Offer recommendations, including rationale, for physical and nutritional interventions; and
- Provide recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	assessment/review or Physical and Nutritional Management Plan (PNMP).										
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	33% 6/18	0/2	0/2	2/2	2/2	0/2	0/2	0/2	1/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	11% 2/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	17% 3/18	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 PNM issues for which nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing IHCPs. These included risks related to: constipation/bowel obstruction, and weight for Individual #140; cardiac disease, and weight for Individual #50; choking, and falls for Individual #138; aspiration, and fractures for Individual #79; choking, and falls for Individual #63; falls, and weight for Individual #115; weight, and constipation/bowel obstruction for Individual #85; choking, and falls for Individual #29; and aspiration, and falls for Individual #97.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP.

b. Those that included sufficient preventative interventions to minimize the condition of risk were those for choking, and falls for Individual #138; aspiration, and fractures for Individual #79; falls for Individual #29; and falls for Individual #97.

c. Of the nine individuals reviewed, Individual #50 did not require a PNMP and/or Dining Plan. All of the PNMPs and/or Dining Plans reviewed included a number of the necessary components to meet the individuals' needs. However, none of the PNMPs fully addressed the individuals' needs. On a positive note, all of the PNMPs/Dining Plans reviewed had been updated in the last 12 months; and included instructions related to transfers, bathing, and medication administration (including positioning, texture, consistency, and adaptive equipment). Problems varied across PNMPs. As applicable to the individual, most included risk levels related to supports and individual triggers, if applicable; descriptions of adaptive equipment the individuals used; instructions related to mobility; handling precautions and moving instructions; mealtime instructions (including both oral and non-oral means); oral hygiene instructions, including positioning and brushing instructions; and communication information. Significant problems were noted with regard to, as applicable to the individuals: photographs that did not provide clear reference for staff; lack of positioning instructions; and lack of toileting instructions, including personal care.

f. The IHCPs that identified triggers and actions to take should they occur were for cardiac disease for Individual #50, and choking for

Individual #138. g. The IHCPs that defined the frequency of monitoring were those for aspiration for Individual #79, constipation/bowel obstruction for Individual #85, and falls for Individual #97.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1				0/1					
Comments: a. Clinical justification for total or supplemental enteral nutrition was not found in the IRRF for Individual #79. The IRRF stated: "The PNMT nurse indicated that [Individual #79] continues with the medical necessity to continue with enteral nutrition as she will aspirate if she is changed to oral feedings as she continues to have the diagnosis of Dysphagia. She recommended that the PCP fill [sic] the needed information to justify the need to continue with the enteral nutrition. The team agreed."											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual receives timely screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	0% 0/7	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/4	N/A	0/1	0/1	N/A	N/A	0/1	0/1	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/5	0/1	N/A	N/A	0/1	0/1	N/A	N/A	0/1	0/1

Comments: a. and b. The following provide examples of concerns noted:

- An OT was not available at the Facility until shortly prior to the Monitoring Team's onsite review. As a result, most of the

individuals did not have the benefit of an OT assessment.

- Individual #50 had a screening completed at the time of his admission. However, no OT was involved to determine whether or not he was in need of OT supports and services. In addition, he should have had a more comprehensive assessment to address his obesity (e.g., endurance for exercise, etc.).
- Individual #115 was readmitted to the Facility after having been gone for approximately six months. The PT completed an update, but the Facility did not have an OT at the time. Therefore, the update was not sufficient to identify and address his needs.
- For the OT/PT assessments and updates reviewed, the 10-day deadline prior to ISP meetings was not consistently met.

d. and e. Now that the Facility has an OT on staff, efforts should be made to ensure that individuals' OT/PT assessments address the following, and updates provide updates on the following:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings;
- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/7	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1

b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	17% 1/6	N/A	N/A	N/A	1/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	0% 0/3	N/A	N/A	N/A	N/A	N/A	0/2	N/A	N/A	0/1

Comments: d. Concerns noted included:

- On 10/22/15, an intervention was initiated for Individual #115 with the restorator, but it was not included in the ISP. In addition, in the ISPA meeting, on 1/8/16, goals/objectives were not established for PT interventions.
- For Individual #97, the PT assessment referenced the use of the restorator, but the IDT did not address it in the ISP.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual receives timely communication screening and/or assessment:										

	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	0% 0/1	N/A	0/1		N/A	N/A		N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	33% 2/6	0/1	N/A		0/1	0/1		0/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	29% 2/7	0/1	0/1		0/1	0/1		0/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	0% 0/5	0/1	0/1		0/1	0/1		0/1	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	0/1	0/1		0/1	0/1		0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	N/A		N/A	N/A		N/A	0/1	0/1
Comments: Individual #138 and Individual #115 did not receive/require communication supports and were part of the outcome sample. Therefore, the Monitoring Team did not score these indicators for them. a. and b. Only screenings were completed for a number of individuals (i.e., Individual #140, Individual #50, Individual #79, Individual #63, and Individual #85) that should have had comprehensive assessments to identify their needs and recommend, as appropriate,											

communication supports. For example, Individual #50 had a stated desire to learn to read and communicate by speaking English. Although the IDT developed a leisure goal to identify the sign for restroom, the SLP only conducted a screening, as opposed to a comprehensive communication assessment, including, as appropriate, recommendations related to the individual's stated goal.

Some individuals received only screenings, but should have received a comprehensive assessment/update. Some individuals did not have communication assessments or screenings completed within 10 working days prior to their ISP meetings.

c. For a number of individuals reviewed for whom communication screenings were completed, Facility staff used a checklist. This resulted in weak screenings, with limited functional information about how an individual communicated. For example one question was "Can the individual communicate?" As another example, there was no discussion of the relevance of the individual's diagnoses, but rather a yes/no answer was documented in response to the prompt: "Risks in relevant Dx/Active problems related to communication."

d. As noted above, five individuals that should have had comprehensive communication assessments did not (i.e., Individual #140, Individual #50, Individual #63, Individual #79, and Individual #85).

e. Individual #29 and Individual #97 had communication updates. On a positive note, both addressed the following to the depth necessary to meet the individuals' strengths, needs, and preferences:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- The individual's preferences and strengths are used in the development of communication supports and services (e.g., Individual #29's preference for music was addressed in the assessment).
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- Analysis of the effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Based on the problems identified in these updates, moving forward, the Facility should focus on ensuring communication updates address, as appropriate:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.	29% 2/7	0/1	0/1	N/A	1/1	1/1	N/A	0/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	33% 1/3	N/A	N/A		N/A	N/A		0/1	0/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	80% 4/5	N/A	N/A		N/A	N/A		0/1	2/2	2/2
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. At times, ISPs included incomplete descriptions of individuals' communications skills. In addition, for a number of individuals reviewed, ISPs did not describe how others should communicate with the individual. c. Individual #85's ISP copied text from the communication screening that stated staff should refer to the communication strategies. However, neither the ISP nor the screening outlined specific communication strategies.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	100% 26/26	3/3	3/3	2/2	3/3	3/3	3/3	3/3	3/3	3/3

3	The individual's SAPs were based on assessment results.	54% 14/26	3/3	2/3	1/2	0/3	2/3	1/3	2/3	1/3	2/3
4	SAPs are practical, functional, and meaningful.	27% 7/26	0/3	1/3	0/2	0/3	1/3	2/3	1/3	1/3	1/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/26	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were only two SAPs available for review for Individual #45, for a total of 26 for this review.

2. All of the SAPs were measurable.

3. Fifty-four percent of the SAPs were based on assessments. The majority of SAPs scored as not based on assessments had FSAs that indicated that the individuals already possessed the skill (e.g., Individual #123's tooth brushing SAP).

4. Twenty-seven percent of the SAPs appeared to be practical and functional (e.g., Individual #133's make a purchase SAP). The SAPs that were judged not to be practical or functional either appeared to represent a compliance issue rather than a new skill (i.e., Individual #140's shredding paper SAP), or were skills that assessments had indicated the individual already possessed (i.e., Individual #150's sweep the floor SAP).

5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data).

Improving the reliability of SAP data should be a priority for the facility.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.

			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
10	The individual has a current FSA, PSI, and vocational assessment.	67% 6/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments:

10. Individual #50 did not have a PSI. Individual #65 and Individual #92's PSI's were more than 12 months old.

11. No data concerning the availability of PSIs to the IDT prior to the ISP were available. Additionally, Individual #123's FSA and Individual #128, Individual #150, Individual #50, Individual #45, and Individual #92's vocational assessments were not available to the IDT at least 10 days prior to the ISP.

12. Individual #92, Individual #65, Individual #45, Individual #50, Individual #140, Individual #128, Individual #123, and Individual #133's FSAs did not include recommendations for skill acquisition.

Domain #3: Individuals in the Target Population will achieve optimal physical, mental, and behavioral health and well-being through access to timely and appropriate clinical services.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
			Individuals:								
#	Indicator	Overall Score									
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	N/A									
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	N/A									
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	N/A									
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	N/A									
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	N/A									
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address	N/A									

	them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	N/A									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	N/A									
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	N/A									
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	N/A									
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	N/A									
Comments: 18-29. None of the individuals at Rio Grande SC were reported to have been placed in restraints more than three times in any rolling 30-day period in the last six months.											

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
1	If not receiving psychiatric services, a Reiss was conducted.	0% 0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, two individuals were not receiving psychiatric services (Individual #29, Individual #85). There was no evidence presented indicating that these individuals were assessed utilizing the Reiss screen.											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when individuals were deteriorating and experiencing increases in psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. There was an indication that each of the nine individuals had experienced a decline in their clinical status at some point in this review period. Documentation was present which indicated that the psychiatry department responded to these episodes in a timely manner and their recommendations were implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
24	The psychiatrist participated in the development of the PBSP.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A

Comments:
23. While the target behaviors (e.g., behavioral challenges) identified for monitoring were consistent, what was lacking is how these behaviors related to the specific psychiatric diagnosis.

24. In general, the psychiatrist referenced the PBSP in either/both annual evaluations and quarterly clinical documentation. In

addition, there were examples of the psychiatrists' participation in the development of the PBSP. In five examples, the PBSP was out of date.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	67% 2/3	1/1	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A
26	Frequency was at least annual.	33% 1/3	0/1	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	67% 2/3	1/1	N/A	N/A	N/A	0/1	1/1	N/A	N/A	N/A

25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to three of the individuals. In the case of Individual #140, information indicated that the last neurology consultation occurred in 2013.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
33	Quarterly reviews were completed quarterly.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/3	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33. Individuals were generally seen quarterly in a timely manner.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing two to four components, most commonly, the presentation of data and review of the implementation of non-pharmacological interventions.

35. Psychiatry clinic was not observed for individuals included chosen for review. Three clinical encounters, however, were observed for other individuals (Individual #2, Individual #59, Individual #105). In these three clinics, there was good discussion led by the psychiatrist, however, presentation of stale graphed data and more recent data were not aggregated, hindering the psychiatrist's ability

to render data driven decisions regarding the efficacy of psychotropic medications.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 36. Assessments were occurring in a timely manner. The documents were reviewed and signed on paper and not in the Avatar system. The paper review included the clinical correlation documentation for all nine examples.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
Comments: 37-39. There was evidence of frequent additional psychiatric reviews when an individual was clinically unstable or when medication adjustments had been made.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-41. There was no indication that the facility used daily psychotropic medication to sedate individuals for the convenience of staff or for punishment. There was concern regarding the use of multiple medications for crisis intervention chemical restraint and pretreatment sedation (e.g., intramuscular combination of Haldol, Ativan, and Benadryl). The facility provided data showing two occurrences for restraint and two occurrences for pretreatment sedation. Even so, the facility should review the usage of this level of medications.

43. The facility did not use PEMA.

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.

			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1	1/1
45	There is a tapering plan, or rationale for why not.	100% 4/4	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 4/4	N/A	N/A	1/1	N/A	N/A	1/1	N/A	1/1	1/1

Comments:
44-45. These indicators applied to four individuals. Polypharmacy justification was appropriately documented in all four cases. Justification should reference the pharmacological attributes of the medication and why these particular medications were chosen.

46. The polypharmacy meeting minutes were comprehensive and documented review of the four individuals who met criterion for polypharmacy. The polypharmacy committee meeting was observed during the monitoring visit. The meeting was well run and evidenced a critical review of the polypharmacy regimens.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
6	The individual is making expected progress	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/3	0/1	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/3	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1	N/A
9	Activity and/or revisions to treatment were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

6. Individual #150, Individual #128, Individual #50, Individual #45, and Individual #92's progress notes indicated that they were making progress (or continued at a low rate of target behaviors) on one or more target behavior in the PBSP, however, the data were not demonstrated to be reliable (see indicator #5), so these individuals were not scored as progressing.

7. Individual #128's exposure and public masturbation target behaviors were achieved in February 2016, but continued with same objective into March 2016. Individual #45's SIB objective appeared to be achieved in June 2015, however, it continued unchanged in March 2016. Individual #92's disruption and aggression objectives appeared to be achieved in September 2015, but continued into March 2016.

8. Individual #45 and Individual #128 were not making progress on their reducing physical aggression objectives, however, their progress notes did not include actions to address the absence of progress. Similarly, Individual #140's disruption and aggression did not appear to be improving, however, her progress notes indicated no action to address her absence of progress.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
17	There was a PBSP summary for float staff.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A

	completed, BCBA coursework.										

Comments:
16. None of the individuals had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained in their implementation.

17. Rio Grande SC utilized a brief PBSP for all individuals.

18. All individuals' functional assessments and PBSPs were written by a BCBA.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
19	The individual's progress note comments on the progress of the individual.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
20	The graphs are useful for making data based treatment decisions.	14% 1/7	0/1	0/1	1/1	0/1	0/1	N/A	0/1	0/1	N/A
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:
19. All individuals had progress notes that commented on the individual's progress.

20. All progress notes had graphs. Individual #45's graph encouraged data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. The usefulness of encouraging data based decisions was limited for the remaining graphs, however, because multiple behavioral data paths were combined with medication bar graphs in the same figure, resulting in the masking of behavioral trends. It is suggested that the figures be simplified (by either separating graphs with medication and target behaviors, or graphing target behaviors and indicating medication changes with phase lines) to encourage meaningful visual inspection of each individual's PBSP data.

21. None of the individual's reviewed had psychiatric meetings during the onsite review. In order to score this indicator, the

Monitoring Team observed a quarterly psychiatric clinic meeting for Individual #105. In this meeting, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. Rio Grande SC did not conduct peer review

23. Rio Grande SC's two BCBAs and a BCBA consultant routinely met to review individual's functional assessments and PBSPs. These meetings did not, however, contain minutes and often involved the review of PBSPs that were required for annual review/revision. Peer review should include the presentation and discussion of individuals for clinical reasons, not because an annual review is due. In other words, peer review should occur due to the lack of progress or because the behavioral health specialist requires some assistance from the peer review committee to improve clinical services. The facility should have peer review weekly, and once a month include someone from outside of the facility (external peer review). Both internal and external peer review should have meeting minutes that aid the facility in following-up on recommendations from peer review meetings.

Outcome 8 – Data are collected correctly and reliably.

#	Indicator	Overall Score	Individuals: 92	65	45	50	140	133	150	128	123
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A

Comments:
26. The data collection system for measuring undesired (target) behaviors was an ABC system for all individuals and for all target behaviors. This system, that requires the DSP to record antecedents and consequences for each target behavior, is generally used for low frequency behaviors. For higher frequency target behaviors, however, it represents a substantial recording burden for DSPs and, therefore, is often found to be associated with underreported data.

It is suggested that the data system for the collection of target behaviors be redesigned to be flexible enough to record both high and low frequency target behaviors (e.g., frequency and interval recording), and time-based target behaviors (e.g., duration measures). It is also recommended that the data collection system be designed so that staff are encouraged to record data as soon as possible after the target behavior occurs. One way to accomplish this is requiring that data are recorded at regular intervals, and that if the target did not

occur, a zero is scored so that data collection timeliness can be directly assessed.

In addition to ensuring reliability of data collection, the behavioral health services department should prioritize this area for improvement.

27. The data collection system for measuring replacement behaviors was adequate.

28. There were established measures of IOA and treatment integrity. There were no established measures of data collection timeliness. Based on a review of the treatment integrity and IOA form, the measures were adequate.

29. Rio Grande SC had established a schedule (once a quarter) and a minimum level (80%) of IOA, and treatment integrity for each individual's PBSP. None of the individuals had a schedule or level of data collection timeliness established.

30. Individual #45 had an IOA assessment in the last six months. He did not have, however, any treatment integrity or data collection timeliness measures in the last six months. None of the other individuals had any IOA, data collection timeliness, or treatment integrity measures in the last six months.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #140 – other: anemia, and constipation/bowel obstruction; Individual #50 – diabetes, and cardiac disease; Individual #138 – constipation/bowel obstruction, and other: hypothyroidism; Individual #79 – cardiac disease, and osteoporosis; Individual #63 –

circulatory, and other: anemia; Individual #115 – cardiac disease, and seizures; Individual #85 – cardiac disease, and constipation/bowel obstruction; Individual #29 – cardiac disease, and osteoporosis; and Individual #97 – respiratory compromise, and osteoporosis).

None of the goals/objectives reviewed were clinically relevant, achievable, and/or measurable and time-bound.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual receives timely preventative care:										
	i. Immunizations	67% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
	ii. Colorectal cancer screening	100% 6/6	1/1	N/A	N/A	1/1	1/1	N/A	1/1	1/1	1/1
	iii. Breast cancer screening	50% 2/4	1/1	N/A	N/A	0/1	0/1	N/A	1/1	N/A	N/A
	iv. Vision screen	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A
	v. Hearing screen	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	50% 1/2	N/A	N/A	1/1	N/A	N/A	N/A	0/1	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
	Comments: a. The following problems were noted:										

- For Individual #140, her hearing was tested on 11/13/14, with a recommendation to follow-up in one year. No evidence was found that this occurred.
- Individual #79 had an abnormal mammogram in 2012, with a benign breast biopsy. No further mammograms were documented. She was noted to be "Uncooperative," but it was unclear what plan the IDT had developed to gain her cooperation. In addition, she was a 63-year-old with no documentation of pneumococcal conjugate vaccine 13 (PCV13). She had a history of pneumonia, including bacterial pneumonia, as well as chronic bronchitis. On 4/4/16, Individual #79 had an Interferon Gamma Release Assay (IGRA) done that was indeterminate. There was no IPN submitted for this. It is important that this study be repeated so that a determination of the individual's tuberculosis status can be made.
- For Individual #63, no mammogram report was submitted, only the letter of referral, dated 9/2/15. The AMA stated it was done on 5/20/15.
- Individual #85's last cervical cancer screening occurred in 2002. Although an IPN, dated 3/4/16, indicated that a discussion about a PAP smear would occur with the gynecologist, no outcome of such a discussion was documented.
- Individual #29 and Individual #97 did not have documentation of the administration of PCV13.

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. Some examples of problems included:

- Abnormal Hemoglobin (Hb) A1C was not addressed for Individual #50 or Individual #63.
- Individual #138's PCP concluded that she did not have metabolic syndrome, despite the fact that she met three criteria.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

#	Indicator	Overall Score	Individuals: 140	50	138	79	63	115	85	29	97
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									
	Comments: In response to the Monitor's pre-review document request, the Center indicated that no one served had a DNR Order.										

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

#	Indicator	Overall Score	Individuals: 140	50	138	79	63	115	85	29	97
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	55% 6/11	1/1	0/1	0/2	1/1	1/1	2/2	1/1	0/1	0/1

b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	30% 3/10	1/1	0/1	0/2	0/1	0/1	1/2	N/A	0/1	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	50% 2/4	1/1	N/A	N/A	0/1	N/A	N/A	N/A	1/2	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 1/1	N/A			N/A				1/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	75% 3/4	1/1			0/1				2/2	
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 4/4	1/1			1/1				2/2	
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	0% 0/3	0/1			0/1				0/1	
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	25% 1/4	0/1			0/1				1/2	

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 11 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #140 – hyperglycemia on 3/29/16; Individual #50 – paresthesia/ADR on 11/24/15; Individual #138 – human bite on 11/10/15, and human bite on 2/15/16; Individual #79 – right lower extremity trauma on 1/14/16, Individual #63 – toe contusion on 2/29/16; Individual #115 – toe cellulitis on 1/22/16, and head trauma on 2/28/16; Individual #85 – hemorrhoids on 2/5/16; Individual #29 – urinary tract infection (UTI) on 1/6/16; and Individual #97 – positive IGRA on 4/4/16.

For these acute issues, medical providers at Rio Grande State Center followed accepted clinical practice in assessing the following: Individual #140 – hyperglycemia on 3/29/16, Individual #79 – right lower extremity trauma on 1/14/16, Individual #63 – toe contusion on 2/29/16, Individual #85 – hemorrhoids on 2/5/16, and Individual #115 – toe cellulitis on 1/22/16, and head trauma on

2/28/16.

Concerns regarding the assessment of the remaining acute issues varied. However, in one or more instance, PCPs did not: conduct timely assessments; review the history of the problem; document the source of the information; conduct and document a focused physical examination, including documentation of all positive and negative findings; review and summarize the most recent diagnostic tests, including normal or negative results; make a definitive or differential diagnosis that clinically fits the corresponding evaluation or assessment(s); and/or document a plan for further evaluation, treatment, and monitoring, including detail, as needed, regarding the monitoring the PCP and/or nursing staff are expected to complete.

The following provide some examples of concerns noted:

- On 11/24/15, the PCP documented that two days after starting Mobic, Individual #50 was evaluated for bilateral foot paresthesias. The Mobic was discontinued. Paresthesias are not a common side effect of Mobic. However, on 10/28/15, the individual was started on Topirimate. The dose was doubled every seven days over three weeks. Paresthesia is a common side effect of topirimate. It often resolves with continued use. INH and pyridoxine were prescribed for latent tuberculosis infection. INH is also associated with the development of paresthesia. Per the IPN documentation, consideration was not given to these agents as the potential etiology of the paresthesia. The Center did not include an ADR form in the document request for the reported Mobic ADR.
- On 11/10/15, another individual bit Individual #138. On 11/13/15, the PCP documented an assessment in the IPN. The IPN indicated the individual had an abrasion to the right forearm that was being treated with topical antibiotic ointment, was scabbed over, and had no evidence of infection. Human bite wounds should be assessed promptly to determine the need for antibiotic prophylaxis. Moreover, the status of both individuals should be documented relative to the potential to transmit infectious diseases (e.g., Hepatitis B and HIV). This status should be reviewed and documented for both individuals with interventions ordered, as deemed necessary. Again, on 2/15/16, another individual bit Individual #138 on the upper lip. The PCP did not document an IPN until 2/17/16, indicating the wound was now healed without evidence of infection. Again, there was no documentation of infection control issues related to this bite.

  In addition, on 2/17/16, Individual #138 was concerned about pregnancy. However, in the IPNs submitted there was no further discussion of the possible pregnancy, despite the fact that the PCP ordered a pregnancy test.
- According to nursing documentation, on 1/6/16, Individual #29 was noted to have an unsteady gait. Several hours later, the IPNs noted the individual was started on Bactrim for a UTI. There was no physician IPN documentation related to this assessment.
- On 4/7/16, the PCP noted that Individual #97 had a positive IGRA on 4/4/16, and was being referred to the health department. There was no assessment of the individual (i.e., no documentation of a physical exam or review of systems to determine if there were signs or symptoms of active infection). On 4/14/16, the covering MD documented that he conducted a record review and found documentation that the individual had a history of a positive tuberculosis skin test many years ago and received the appropriate treatment with INH for latent tuberculosis infection. Per the MD, in light of the absence of clinical findings, it was reported that the health department made no further recommendations. This individual's history should be clearly documented in the AMA and the IRRF. The IHCP should include current Centers for Disease Control (CDC) recommendations for this clinical scenario.

b. Follow-up was not applicable for Individual #85 for hemorrhoids on 2/5/16. The acute events for which providers conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilized were Individual #140 – hyperglycemia on 3/29/16, Individual #115 – head trauma on 2/28/16, and Individual #97 – positive IGRA on 4/4/16, for whom the covering MD reviewed the health department's consultation.

For three of the nine individuals reviewed, the Monitoring Team reviewed four hospital admissions, or ED visits, including the following with dates of occurrence: Individual #140 – mental status changes on 11/2/15; Individual #79 – influenza/pneumonia on 2/17/16; and Individual #29 – pneumonia on 1/9/16, and pneumonia/hypovolemia/fecal impaction on 1/10/16.

c. PCP IPNs were not found within one business day of the individuals' transfers for Individual #79 – influenza/pneumonia on 2/17/16, and Individual #29 – pneumonia/hypovolemia/fecal impaction on 1/10/16.

d. Three of the acute illnesses reviewed occurred after hours or on a weekend/holiday. For the remaining acute illness, it was positive that a quality assessment was documented in the IPNs.

e. For the acute illnesses reviewed, it was positive the individuals reviewed generally received timely treatment at the SSLC. The exception was for Individual #79 – influenza/pneumonia on 2/17/16.

f. It was positive that when these individuals were transferred to the hospital, documentation was submitted to confirm that the PCP or nurse communicated necessary clinical information with hospital staff.

h. For Individual #29 – pneumonia on 1/9/16, there was evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of the acute illness.

The following provide some examples of concerns for individuals who were transferred out of the Facility:

- For Individual #140 – mental status changes on 11/2/15, the only IPN was dated 11/3/15, and was the IPN summarizing the reason for the initial transfer to the hospital.
- On 2/16/16, nursing staff made several IPN entries related to Individual #79 complaining her stomach hurt and that she did not feel well. It was also documented that the individual had a cough and a runny nose. In the early morning of 2/17/16, the individual was noted to have deterioration in status. She was lethargic, then unresponsive and was noted to be hypoxic and hypotensive. At that time, she was transferred to the ED and admitted to the hospital with a diagnosis of influenza, UTI, and possible pneumonia. On 2/19/16, she returned to the Facility. On 2/20/16, she was transferred to the hospital again and admitted with bacterial pneumonia until 2/23/16. The Facility submitted no physician documentation for this event, including no documentation of a medical assessment prior to transfer or upon return to the Facility.
- On 1/6/16, Individual #29 was diagnosed with a UTI and started on Bactrim. No MD note was submitted for this diagnosis. On 1/8/16, the PCP documented that the individual was being seen for follow-up, and for new reports of cough and wheezing. The PCP noted that the individual had a good appetite and "has been well." No upper respiratory infection signs or symptoms noted on 1/6/16 or on 1/8/16. On 1/9/16, the covering PCP referred the individual to the ED for evaluation due to an abdominal x-

ray that showed an ileus, and poor appetite for two days. The individual returned to the Facility with the diagnosis of bacterial pneumonia, and was treated with Levaquin. On 1/10/16, the covering PCP noted that a chest x-ray would be repeated and labs obtained from the hospital. The plan was to continue to monitor the individual. Individual #29 was unable to swallow food and had little oral intake. Staff reported that he was not his usual calm, quite happy self. He was referred back to ED, admitted, and discharged on 1/20/16, with diagnosis of hypovolemia, fecal impaction, and abnormal chest x-ray chest computerized tomography (CT). Bronchoscopy was reported to be unremarkable. On 1/20/16, a post-hospital note was written, which was the only follow-up note.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.

#	Indicator	Overall Score	Individuals: 140	50	138	79	63	115	85	29	97
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	39% 7/18	0/2	0/2	2/2	0/2	2/2	1/2	2/2	0/2	0/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	50% 9/18	2/2	0/2	2/2	0/2	2/2	1/2	2/2	0/2	0/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 6/6	N/A	N/A	2/2	N/A	2/2	1/1	1/1	N/A	N/A
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/2	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #140 for ophthalmology on 1/28/16, and dental on 10/8/15; Individual #50 for urology on 1/14/16, and Ear, Nose, and Throat (ENT) on 1/14/16; Individual #138 for dental on 12/14/15, and well-woman exam on 11/18/15; Individual #79 for ophthalmology on 1/26/16, and cardiology on 11/30/15; Individual #63 for audiology on 2/8/16, and dental on 2/1/16; Individual #115 for neurology on 2/11/16, and gastroenterology of 3/15/16; Individual #85 for hematology/oncology on 2/15/16, and dental on 10/26/15; Individual #29 for cardiology on 3/2/16, and ophthalmology on 2/10/16; and Individual #97 for neurology on 3/3/16, and eye on 2/10/16.

a. PCPs indicated agreement or disagreement, and provided rationale for any disagreement with the recommendations for Individual #138 for dental on 12/14/15, and well-woman exam on 11/18/15; Individual #63 for audiology on 2/8/16, and dental on 2/1/16; Individual #115 for neurology on 2/11/16; and Individual #85 for hematology/oncology on 2/15/16, and dental on 10/26/15.

b. PCPs completed reviews timely for Individual #140 for ophthalmology on 1/28/16, and dental on 10/8/15; Individual #138 for dental on 12/14/15, and well-woman exam on 11/18/15; Individual #63 for audiology on 2/8/16, and dental on 2/1/16; Individual #115 for neurology on 2/11/16; and Individual #85 for hematology/oncology on 2/15/16, and dental on 10/26/15.

c. For the consultations reviewed, PCPs did not write corresponding IPNs that included the information that State Office policy requires.

d. It was positive that when PCPs documented agreement with consultation recommendations, evidence was submitted to show they were ordered.

e. The consultation report for Individual #63 for audiology on 2/8/16 indicated mild hearing loss. This information should have been reported to and discussed by the IDT to determine if modifications to supports were needed.

The results of the consultation for dental for Individual #138 on 12/14/15 should have been referred to IDT for discussion related to the use of general anesthesia.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	61% 11/18	2/2	0/2	1/2	2/2	1/2	1/2	1/2	2/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #140 – other: anemia, and constipation/bowel obstruction; Individual #50 – diabetes, and cardiac disease; Individual #138 – constipation/bowel obstruction, and other: hypothyroidism; Individual #79 – cardiac disease, and osteoporosis; Individual #63 – circulatory, and other: anemia; Individual #115 – cardiac disease, and seizures; Individual #85 – cardiac disease, and constipation/bowel obstruction; Individual #29 – cardiac disease, and osteoporosis; and Individual #97 – respiratory compromise, and osteoporosis).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #140 – other: anemia, and constipation/bowel obstruction; Individual #138 – other: hypothyroidism; Individual #79 – cardiac disease, and osteoporosis; Individual #63 – circulatory; Individual #115 – seizures; Individual #85 – cardiac disease; Individual #29 – cardiac disease, and osteoporosis; and Individual #97 – osteoporosis.

Some examples of concerns included:

- According to Individual #50's IRRF, his mother reported that he individual was treated in the past for diabetes, but was on no medications for diabetes at the time of admission. The mother indicated that the individual was diagnosed with diabetes

mellitus at the age of 14, and was treated with metformin and subcutaneous insulin. The insulin was discontinued due to misuse. The IRRF noted that the baseline HbA1c was 5.7, and stated that this was within normal parameters. However, an HbA1c level of 5.7 is not considered normal. This HbA1c and the individual's obesity (i.e., 305 pounds with an abdominal girth of 52 inches), along with a diagnosis of hypertension were sufficient to warrant close follow-up, a repeat A1c, and lifestyle changes. The PCP had not included a plan in the AMA to address the history of diabetes mellitus II or metabolic syndrome. On 10/2/15, the next HgA1c was obtained, and was 7.8, which clearly indicated uncontrolled hyperglycemia. The individual was then started on metformin and satagliptin. The individual has shown improvement in glycemic control.

- For Individual #138, the PCP did not address the diagnosis of constipation (i.e., it was not listed as an active diagnosis and no plan was included in the AMA), even though medication was prescribed for the condition and the individual remained at risk due to psychotropic medications.
- For Individual #63, the AMA plan did not address anemia, even though it appeared the individual received supplemental iron.
- For Individual #85, at time of the AMA, constipation was not an active problem. On 1/14/16, daily milk of magnesia was added. On 2/17/16, the individual's risk rating for constipation was increased to medium risk. The most recent MAR documented that the individual received daily poly ethylene glycol, milk of magnesia, and docusate, as well as scheduled suppositories. The IPNs provided no explanation for this sudden change in bowel habits. The PCP should review factors that contribute to constipation, including a thorough review of the medications prescribed. Non-pharmacologic measures should be implemented, as appropriate.
- For Individual #97, the IRRF did not document that the individual had a previous history of a positive purified protein derivative (PPD) and was treated with isoniazid (INH). The recommendation was to complete yearly tuberculosis testing. The AMA noted that the IGRA was to be done yearly. The covering MD noted the individual had a history of a positive Tuberculin Skin Test and received the appropriate treatment with INH. The plan by the covering MD was consistent with the CDC guidelines, which state when the individual has documentation of appropriate therapy for latent tuberculosis infection (LTBI), further testing is not indicated unless the individual exhibits signs or symptoms of disease or has contact with a multi-drug resistant case of tuberculosis. The PCP should review the individual's record, treatment history, and recommendations from the local health department. A plan should be developed based on all data and should be clearly documented in the AMA/Quarterly Medical Summaries, and IRRF/IHCP. The IRRF and IHCP should provide information for staff related to monitoring for signs and symptoms of tuberculosis infection.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	73% 11/15	N/A	1/2	0/1	2/2	1/2	2/2	2/2	2/2	1/2

Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed were assessed for completion. Those for which documentation was submitted to show they were completed were for Individual #50 – cardiac disease; Individual #79 –

cardiac disease, and osteoporosis; Individual #63 – circulatory; Individual #115 – cardiac disease, and seizures; Individual #85 – cardiac disease, and constipation/bowel obstruction; Individual #29 – cardiac disease, and osteoporosis; and Individual #97 – osteoporosis.

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	NR									
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	NR									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	QDRRs are completed quarterly by the pharmacist.	44% 8/18	1/2	1/2	1/2	1/2	1/2	0/2	1/2	1/2	1/2

b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	71% 12/17	0/2	1/2	2/2	2/2	0/2	1/1	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 8/8	2/2	1/1	2/2	1/1	N/A	N/A	N/A	N/A	2/2
	iii. Medication polypharmacy;	100% 7/7	1/1	N/A	2/2	1/1	N/A	1/1	N/A	N/A	2/2
	iv. New generation antipsychotic use; and	67% 8/12	0/2	1/1	0/2	2/2	2/2	1/1	N/A	N/A	2/2
	v. Anticholinergic burden.	93% 13/14	2/2	1/1	2/2	2/2	2/2	1/1	2/2	N/A	1/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 17/17	2/2	2/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 13/13	2/2	2/2	2/2	2/2	2/2	1/1	N/A	N/A	2/2
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	100% 9/9	1/1	1/1	1/1	2/2	1/1	N/A	1/1	1/1	1/1

Comments: Only one recent QDRR was submitted and reviewed for Individual #115 (i.e., the other was completed on 2/18/15).

b.i through b.v. The following provide examples of some of the concerns noted:

- For Individual #140, the Pharmacist documented in the QDRR, dated 12/1/15, that the comprehensive metabolic panel (CMP) showing a glucose of 135 was non-fasting. The Pharmacist should have recommended that the PCP obtain a fasting blood glucose, particularly since this individual had a previously elevated HbA1c of 5.7. Moreover, the Clinical Pharmacist stated that the individual was not at risk for metabolic syndrome. The individual was at risk and actually met several criteria for the clinical diagnosis of metabolic syndrome, including "uncontrolled dyslipidemia," the use of statins for treatment of hyperlipidemia, and elevated blood glucose.

  In the 8/28/15 QDRR for Individual #140, the Pharmacist documented that the individual's HbA1C was 5.7, but did not make the recommendation to repeat it for verification. This QDRR noted that the individual was at risk for metabolic syndrome citing the use of new generation antipsychotics (NGAs), hypertension (treated with Lisinopril), and dyslipidemia.

The QDRR worksheet states at risk is "Defined as central obesity + any 2 other risk factors." There is a distinction between risk factors and the criteria for the clinical diagnosis of metabolic syndrome. Diagnostic criteria are listed in the worksheet table, but are cited as "risk factors." This list of risk factors does not include the important risk of use of NGAs. The use of NGAs increases risk for development of metabolic syndrome. However, the use of NGAs is not a diagnostic criterion. It should also be noted that the diagnosis of metabolic syndrome does not require the presence of abdominal obesity. Per the American Heart Association, the clinical diagnosis of metabolic syndrome can be made when any three of the five criteria are met. A list of the five criteria can be found at: http://circ.ahajournals.org/content/112/17/2735.full.

- For Individual #50, the comments in the 11/30/15 QDRR listed several monitoring parameters for the use of topirimate. However, the Pharmacist made no recommendations, such as how to monitor for the development of nephrolithiasis as noted. Also, the Pharmacist made no comment on topirimate relative to the reported paresthesias. The QDRR indicated Mobic was source of the ADR, but the Pharmacist did not submit an ADR form.
- The QDRR, dated 3/8/16, for Individual #138 stated: "individual currently meets the definition for metabolic syndrome due to abdominal obesity, low high density lipoprotein (HDL) and use of 2 SGAs." As previously noted, the use of second generation antipsychotics increases risk, but is not one of the five defined American Heart Association criteria. The individual actually had three criteria, including treatment for hyperlipidemia, low HDL, and abdominal obesity.
- Individual #63's QDRRs identified elevated HbA1C readings (i.e., 5.7, and 5.6). According to the American Diabetes Association, an HbA1c level between 5.7 and 6.4 is considered pre-diabetes. However, the Pharmacist did not recommend that the PCP follow-up and/or consider interventions.
- For Individual #97, the Pharmacist made no comments on the continuous use of chlorhexidine.

c. and d. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. When prescribers agreed to recommendations for the individuals reviewed, they implemented them.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	N/A	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7		0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. Individual #85 was edentulous, and Individual #140 was rated at low risk in relation to dental.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Individual #140 and Individual #85 were at low risk for dental, but they were in the core group, so all applicable items were scored for them. For the remaining seven individuals, the Monitoring Team also conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs.	63% 5/8	1/1	0/1	0/1	1/1	1/1	1/1	N/A	1/1	0/1

b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
d.	If the individual has a fair or poor oral hygiene rating, individual receives at least two topical fluoride applications per year.	38% 3/8	0/1	0/1	1/1	1/1	0/1	0/1	N/A	1/1	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	25% 1/4	N/A	0/1	0/1	N/A	N/A	0/1	N/A	1/1	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A

Comments: a. Individual #88 was edentulous. For some individuals, it was difficult to determine what care/treatment they received, because even for appointments with general anesthesia, the Center had not requested/obtained dental notes to document what treatment occurred. At times, a note from the Registered Dental Hygienist (RDH) indicated treatment was provided, but the RDH was not present for the treatment, and no supporting documentation was included in the individual's record.

b. The dentist usually did not document that oral health instructions were given. However, individuals with fair/poor oral health attended dental rehearsal where tooth brushing and flossing were practiced.

c. It was positive that the individuals reviewed had x-rays in accordance with applicable standards.

e. For Individual #50, documentation from the PCP in December 2015 and from a dental evaluation in July 2015, described rampant tooth decay. However, despite an appointment with general anesthesia in January 2016, no documentation was submitted to show that the necessary restorative work was completed.

For Individual #138, a 2015 consult indicated the need for 16 restorations. A new provider schedule dental rehabilitation for May/June 2016.

For Individual #115, a 2/8/16 exam noted that he needed 14 restorations, but at the time of the review, these had not been completed.

On a positive note, Individual #29 had a restorations completed over a number of months without sedation or general anesthesia.

Outcome 6 – Individuals receive timely, complete emergency dental care.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If individual experiences a dental emergency, dental services are	100%	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A

	initiated within 24 hours, or sooner if clinically necessary.	2/2									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A		N/A			N/A				
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 2/2		1/1			1/1				

Comments: a. through c. It was positive that for the two dental emergencies reviewed, individuals had dental services initiated within 24 hours or sooner, and pain management was provided as needed.

Outcome 7 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	33% 1/3	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 1/1			N/A	1/1					N/A
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1			N/A	0/1					N/A
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/1			N/A	0/1					N/A

Comments: Individual #138 and Individual #97 did not have documented assessments to determine whether or not they would benefit from suction tooth brushing.

Outcome 8 – Individuals who need them have dentures.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	13% 1/8	0/1	1/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									

Comments: a. Documentation from the dentist indicated that Individual #50 would have impressions done at the next visit, and that he needed time to heal from the extractions.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	36% 4/11	1/2	0/1	0/1	1/1	N/A	0/2	0/2	2/2	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	60% 6/10	1/1	0/1	1/1	1/1		1/2	0/2	2/2	
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	9% 1/11	1/2	0/1	0/1	0/1		0/2	0/2	0/2	
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	100% 2/2	1/1	N/A	N/A	N/A		N/A	N/A	1/1	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/11	0/2	0/1	0/1	0/1		0/2	0/2	0/2	
f.	The individual's acute care plan is implemented.	0% 0/11	0/2	0/1	0/1	0/1		0/2	0/2	0/2	

Comments: The Monitoring Team reviewed 11 acute illnesses and/or acute occurrences for seven individuals, including Individual #140 – urinary tract infection (UTI) on 10/6/15, and UTI on 11/4/15; Individual #50 – boil acute care plan initiated on 10/19/15; Individual #138 – acute conjunctivitis to chemical (D3 lemocide, which is a lemon-scented disinfectant, deodorant, and cleaner) on 10/15/15; Individual #79 – dermatitis with incontinence (i.e., diaper rash) on 10/18/15; Individual #115 – human bite on10/24/15, and non-displaced fracture to the right 4th finger on 1/10/16; Individual #85 – conjunctivitis on 2/15/16, and pharyngitis on 2/15/16; and Individual #29 – bacterial pneumonia on 1/9/16, and human bite on 10/22/15.

a. The acute illnesses/occurrences for which nursing assessments were performed as soon as symptoms were observed and in alignment with nursing protocols were for Individual #140 – UTI on 11/4/15; Individual #79 – dermatitis with incontinence (i.e., diaper rash) on 10/18/15; and Individual #29 – bacterial pneumonia on 1/9/16, and human bite on 10/22/15.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #140 – UTI on 11/4/15; Individual #138 – acute conjunctivitis to chemical (D3 lemocide, which is a lemon-scented disinfectant, deodorant, and cleaner) on 10/15/15; Individual #79 – dermatitis with incontinence (i.e., diaper rash) on 10/18/15; Individual #115 –non-displaced fracture to the right 4th finger on 1/10/16; and Individual #29 – bacterial pneumonia on 1/9/16, and human bite on 10/22/15.

c. The acute illness/occurrence treated at the Facility for which licensed nursing staff conducted ongoing assessments was for Individual #140 – UTI on 11/4/15.

d. Nursing staff conducted pre- and post-hospitalization assessments for Individual #140 – UTI on 11/4/15; and Individual #29 – bacterial pneumonia on 1/9/16.

e. In some cases, an acute care plan should have been developed, but was not (i.e., Individual #115 for fracture). For those that were developed, some plans included some interventions regarding follow-up nursing assessments that were consistent with the individuals' needs (i.e., those for Individual #140, Individual #50, Individual #138, Individual #115 for human bite, Individual #85 for conjunctivitis, and Individual #129). However, none of the acute care plans were in alignment with nursing protocols; and none included specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; or defined the clinical indicators nursing would measure. The one that identified the frequency with which monitoring should occur was the one for Individual #138 for conjunctivitis.

f. In one case (i.e., Individual #140 – UTI on 11/4/15), the assessments the nurses conducted and documented in the IPNs were complete and met the individual's needs, despite the fact that the acute care plan did not define the assessments nurses should complete in a manner that was consistent with generally accepted standards.

The following provide some examples of concerns noted with regard to this outcome:

- The cleaner that Individual #138 got in her eye is rated "high" on the Hazard Identification System, and the Material Safety Data Sheet stated that it can cause irreversible eye damage and eyes should be flushed with cool water for at least 15 minutes and if irritation persists, obtain medical attention. Nursing staff assessed her shortly after the incident, but the nursing assessment did not include an assessment of Individual #138's vision (e.g., blurred, normal), which would be important in this situation. It was positive that nursing staff timely notified the PCP. Individual #138 was sent to the eye doctor, but nursing staff did not document an assessment before she left and the nursing assessments subsequent to the appointment did not assess her vision. The acute care plan did not include specific criteria for assessment of her eyes (i.e., only assess eye(s) at least daily, and nurse will monitor at each medication pass for signs and symptoms of pain or altered vision/photosensitivity). No documentation was submitted showing that medication nurses addressed her vision or photosensitivity. The daily assessments from nursing only mentioned "no drainage, no swollen, redness from eyes" without any additional assessments of her actual vision.
- For Individual #79's dermatitis with incontinence (i.e., diaper rash) on 10/18/15, although nurses conducted assessments daily, most only noted "red area to groin" without further description regarding whether or not the area was healing appropriately (e.g., odor, drainage, size). The only intervention in the acute care plan was to apply cream twice a day.
- On 10/22/15, an individual bit Individual #115, but the acute care plan was not initiated until 10/24/15, when antibiotics

were prescribed. The initial nursing assessment was completed timely. However, the documentation did not note if the individual's skin was broken from the bite or just had an indentation of teeth marks, if there was any bleeding, or any drainage, and it did not note the appearance of the skin at the site of the bite (e.g., red, swollen). Without this initial information, there was no way to accurately determine the progress of healing and gage the risk of infection. An acute care plan should have been initiated at the time of the acute issue and not just in response to the order for an antibiotic. The acute care plan had one intervention that included a specific timeframe for assessment (daily). However, it did not include specific criteria for assessing the "condition of the wounds." Other interventions were nonspecific, such as "adequate nutrition/hydration" and "sterile technique/aseptic technique" without explanation of the use of these techniques in Individual #115's particular case. Although the acute care plan noted that on 10/24/15, the Infection Control Nurse was notified of the initiation of an antibiotic, there was no documentation indicating that the Infection Control Nurse was notified on the day of the bite (10/22/15), and/or was involved in reviewing the health status of the peer who bit Individual #115 or the acute care plan to ensure it clinically addressed the potential for infection. The ongoing assessments nurses conducted did not contain the necessary information to determine if the wound(s) was healing.

- With regard to Individual #115's non-displaced fracture to the right 4th finger on 1/10/16, at 6:14 p.m., an IPN indicated that Individual #115 had a hold of a staff member's blouse and would not let go. After staff attempted to use verbal prompts, staff began using "PMAB release" one finger at a time. The next IPN at 7:00 p.m. indicated that the individual came to nurses' station and his right ring finger looked swollen and was painful. An IPN noted that there was also some purple discoloration to the palm area close to the ring finger. The nurse did not provide any description of skin temperature, position of finger, or range of motion limitations. It was positive that nursing staff timely notified the PCP. Nursing assessments were completed daily. However, the assessment criteria were not consistent from nurse to nurse, making clinical comparisons impossible. Nursing staff did not develop an acute care plan to address this fracture. Although the IHCP addressed fractures, the IHCP did not include assessment criteria or an acute occurrence of a fracture.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2

b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #140 – falls, and weight; Individual #50 – weight, and other: substance abuse and smoking; Individual #138 – dental, and polypharmacy/side effects; Individual #79 – fractures, and constipation/bowel obstruction; Individual #63 – dental, and falls; Individual #115 – weight, and fractures; Individual #85 – falls, and other: pain related to past spinal surgery; Individual #29 – constipation/bowel obstruction, and falls; and Individual #97 – dental, and behavioral health).

The IHCP that included a clinically relevant, and achievable goal/objective was for Individual #79 – fractures.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provision of nursing supports and services to these nine individuals.

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

#	Indicator	Overall Score	Individuals: 140	50	138	79	63	115	85	29	97
a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.

a. through c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not

meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Outcome 6 – Individuals receive medications prescribed in a safe manner.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual receives prescribed medications in accordance with applicable standards of care.	56% 10/18	1/2	1/2	1/2	1/2	2/2	1/2	1/2	1/2	1/2

b.	Medications that are not administered or the individual does not accept are explained.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	33% 2/6	0/1	0/1	1/1	0/1	N/A	N/A	0/1	1/1	N/A
e.	Individual's PNMP plan is followed during medication administration.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
f.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
i.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	33% 3/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	25% 2/8	N/A	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1

Comments: The Monitoring Team conducted record reviews and observations of nine individuals.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #138, Individual #79, and Individual #29 showed omissions and/or MAR blanks.
- On 2/23/16, and 3/29/16, Individual #140's MAR had initials circled without explanation, and on 3/21/16, no site was documented on the MAR for Ativan 2 milligrams (mg) intramuscular (IM).
- For Individual #50, initials were circled on the MARs for January, February, March, and April 2016 without explanation.
- For a number of medication administration times, Individual #138's MARs had boxes drawn under existing MAR box with

different initials in each box without explanation. Similarly, on 3/22/16, the 7:00 a.m. medications for Individual #97 had initials in the MAR block and a box drawn in underneath with a different set of initials with no explanation. This was a concerning medication practice, because it was unclear if nurses were pre-signing MARs.

- For Individual #79, initials were circled on the February 2016 MAR without explanation. In addition, Dulcolax order for "now" dosages on 3/11/16 were merged with a regular order for routine Dulcolax, which had boxes drawn in under the MAR boxes. In April 2016, a Bisacodyl "now" order also was merged with a routine order. The "now" order and the routine order should have been transcribed separately. Some MARs were very difficult to understand with crossed-out errors with writing over them.
- For Individual #115, initials were circled on the MARs without explanation. In addition, four injections did not have the site documented.
- For Individual #85, initials were circled on the MARs for January, February, and March 2016 without explanation.

Of note, the nurse administering Individual #79's medications via G-tube did an exceptional job, especially for a facility that does not have many individuals with tubes. Lung sounds were assessed before and after medication pass without prompts.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. Nursing staff administered PRN medication, but at times, did not document the reason, route, and/or the individual's reaction or the effectiveness of the medication.

e. It was positive that for the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs.

f. It was positive that for the individuals observed, nursing staff followed infection control practices.

g. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed.

h. When a new medication was initiated, when there was a change in dosage, and after discontinuing a medication, documentation was not present to show individuals were monitored for possible adverse drug reactions.

i. and j. In the initial document request, the Facility indicated that Individual #140 and Individual #50 had potential ADRs in the previous six months. However, in the document provided for the review, the Facility indicated this was not applicable to Individual #140 and Individual #50. Given the problems with the Facility's documentation overall, it is unclear which documentation was correct.

k. As noted above, medication variances (e.g., MAR blanks) occurred without explanation, and without medication variance forms completed, and/or action taken.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/13	N/A	0/2	0/2	0/2	0/2	0/1	N/A	0/2	0/2
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/13		0/2	0/2	0/2	0/2	0/1		0/2	0/2
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/13		0/2	0/2	0/2	0/2	0/1		0/2	0/2
	iv. Individual has made progress on his/her goal/objective; and	0% 0/13		0/2	0/2	0/2	0/2	0/1		0/2	0/2
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/13		0/2	0/2	0/2	0/2	0/1		0/2	0/2

b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	60% 3/5	1/2	N/A	N/A	N/A	N/A	0/1	2/2	N/A	N/A
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/2					0/1	0/2		
	iii. Individual has a measurable goal/objective, including timeframes for completion;	20% 1/5	0/2					1/1	0/2		
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/5	0/2					0/1	0/2		
	v. Individual has made progress on his/her goal/objective; and	0% 0/5	0/2					0/1	0/2		
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/2					0/1	0/2		

Comments: The Monitoring Team reviewed 13 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: cardiac disease, and weight for Individual #50; choking, and falls for Individual #138; aspiration, and fractures for Individual #79; choking, and falls for Individual #63; falls for Individual #115; choking, and falls for Individual #29; and aspiration, and falls for Individual #97.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable, and/or measurable goals/objectives.

b.i. The Monitoring Team reviewed five areas of need for three individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: constipation/bowel obstruction, and weight for Individual #140; weight for Individual #115; and weight, and constipation/bowel obstruction for Individual #85.

Individual #140 (for constipation/bowel obstruction), and Individual #85 (for weight, and constipation/bowel obstruction) were appropriately referred to the PNMT. However:

- Individual #115 experienced significant weight loss, but no evidence was found that his IDT referred him to the PNMT or that the PNMT reviewed him.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT had not developed clinically relevant and achievable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: weight for Individual #115.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/2	0/2	N/A	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/2	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, documentation was not found to confirm the implementation of the PNM action steps that were included. At times, action steps were not measurable (e.g., ongoing), so it could not be determined if they were implemented/met.

b. The following provides some examples related to IDTs' responses to changes in individuals' PNM status:

- Based on the Monitoring Team member's observations, Individual #85's positioning during meals was extremely poor. When the Monitoring Team member brought this to Facility staff's attention, the Speech Language Pathologist (SLP) reported that she requested assistance from the PT to address this issue, but the problem was not addressed. The Facility did not have an OT on staff until shortly before the Monitoring Team's onsite review. The first ISPA meeting held to address weight loss was on 2/11/16. The team discussed a number of issues, but did not develop a clear list of recommendations, and there was no discussion of her mealtime positioning. No OT, PT, or SLP was present at the meeting, although a Registered Dietician did attend.
- For Individual #115, despite significant weight loss, there was no evidence the IDT met to discuss this concern or issues related to meal refusals. On 2/8/16, the diet order to double portions was initiated, although weight loss had occurred prior to that time. He weighed 128 to 129 pounds at time of admission, on 9/28/15, and was as low of 105 pounds in January 2016.
- For Individual #63, on 9/24/15, the IDT met to discuss seven falls reported from 2/10/15 to 7/8/15. Her falls were not addressed in a timely manner. The IDT discussed a decrease in falls with the application of an ankle foot orthosis (AFO), and the psychiatrist also said they decreased after discontinuing Lithium. In an ISPA meeting held on 3/30/16, the IDT discussed

two falls that occurred in December 2015. However, in an ISPA meeting held on 12/14/15, three falls were reported as occurring, including one in October and two in December. In addition to reviews not being timely, the IDT cited different reasons for these falls, including osteopenia of the right hip and osteoarthritis in both knees, left hip replacement and a total knee replacement, as well as an unsteady gait and blindness in her left eye. Further, the PT stated that descriptions of falls appeared to be related to staff not following the PNMP. Although, Lithium was previously stopped due to falls, Lamictal was added, which has similar potential side effects of unsteady gait and dizziness. Not all changes the IDT discussed according to the ISPA documentation were added to her PNMP. Her IDT did not appear to have determined the frequency of falls, and/or the root cause of the problem.

- Individual #140 experienced significant weight loss, but the IDT had not developed a comprehensive plan to address it.

c. Individual #140 was discharged from the PNMT in relation to weight and constipation/bowel obstruction, but no discharge summary was submitted. On 2/16/16, an ISPA meeting was held.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	28% 10/36
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	38% 3/8
Comments: a. The Monitoring Team conducted 36 observations of the implementation of PNMPs and/or Dining Plans. Based on these observations, individuals were positioned correctly during none out of five observations (0%). Staff followed individuals' dining plans during 10 out of 30 mealtime observations (33%). Transfers were completed according to the PNMPs in none of one observation (0%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A									
Comments: This indicator was not applicable to any of the individuals reviewed.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Facility hired an OT shortly before the Monitoring Team's onsite review. However, a number of individuals reviewed did not have the benefit of an OT assessment. As a result, the Monitoring Team could not conclude that individuals did not require formal OT supports and services.

For individuals that did have identified PT needs, goals/objectives were not developed that were clinically relevant, achievable, and/or measurable.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. The Monitoring Team completed full reviews for all nine individuals.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/6	0/2	N/A	N/A	0/1	N/A	0/1	N/A	0/1	0/1

b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/3	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: a. Some examples of the problems noted included:

- Lack of evidence in integrated monthly reviews that supports were implemented.
- In some cases, reviews indicated a lack of progress, but no analysis was included to determine the cause for the lack of progress.
- In some cases, evidence submitted showed limited implementation of programs.

b. For Individual #140, no evidence was submitted to show a meeting of the IDT to approve termination of her programs for physical therapy, or the use of the parallel bars.

For Individual #97, no evidence was submitted to show a meeting of the IDT to approve termination of the use of his restorator, but the evaluation stated that he did not cooperate with this activity

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
			Individuals:								
#	Indicator	Overall Score	140	63	114	131	85	51	115		
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	57% 4/7	0/1	1/1	1/1	1/1	1/1	0/1	0/1		
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	43% 3/7	0/1	1/1	1/1	1/1	0/1	0/1	0/1		
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	29% 2/7	0/1	0/1	1/1	1/1	0/1	0/1	0/1		

Comments: a. The Monitoring Team conducted observations of seven pieces of adaptive equipment. The pieces of adaptive equipment that were not clean were Individual #51's wheelchair, and Individual #115's right AFO. Individual #140 was observed sitting in a chair in the common area of her home in her bare feet, with no shoes, no socks, and no AFOs. Staff were not with her at the time.

b. Examples of problems included:

- During a mealtime, Individual #85 had two contoured pillows, and not the regular pillow that her plan required. The contoured pillows did not provide necessary support throughout the meal.
- Individual #51's cushion was only half on the seat bottom of his wheelchair.
- Individual #140 and Individual #115 did not have their AFOs with them.

c. Some of the problems noted included:

- Individual #63 had a long-handled teaspoon instead of the small-bowled spoon her plan required.
- Based on observation of Individual #85, and Individual #51 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Domain #4: Individuals in the Target Population will engage in meaningful activities, through participation in active treatment, community activities, work and/or educational opportunities, and social relationships consistent with their individual support plan.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: Once Rio Grande SC develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.

4-7. Overall, personal goals did not meet criteria for ISP indicator 1, therefore, there was no basis for assessing progress in these areas. The couple of goals that did meet criteria did not have data to be able to assess progress. See Outcome 7, indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.											
			Individuals:								
#	Indicator	Overall Score	92	50	140	123	79	63			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Staff knowledge regarding individuals' ISPs was insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation. Some direct support professionals, particularly for Individual #92 and Individual

#140, were knowledgeable of many supports, which was positive, but unfortunately they were unfamiliar with their PBSPs.

40. Action steps were not consistently implemented for any individuals. For example:
- Individual #123 refused to participate in most ISP action plans. He had attended one vocational day in six months and nine community outings in same timeframe.
- Individual #140 was supposed to have a service objective for maintaining strength post hospitalization, but did not, and there was minimal implementation of an action plan for using the parallel bars. She had attended her vocational program only 11 days in the past six months.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

#	Indicator	Overall Score	Individuals:								
			92	65	45	50	140	133	150	128	f123
6	The individual is progressing on his/her SAPS	0% 0/26	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/2	N/A	N/A	0/1	N/A	N/A	N/A	N/A	0/1	N/A
8	If the individual was not making progress, actions were taken.	0% 0/24	0/3	0/3	0/1	0/3	0/3	0/3	0/3	0/2	0/3
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/26	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3

Comments:

6. The majority of SAPs (e.g., Individual #140's identify money SAP) were scored as not meeting criterion because they were not making progress. Some SAP data did indicate progress, but were scored as not making progress because they did not have reliable data (e.g., Individual #45's identify his multi vitamin SAP). Individual #133's SAPs had no data available.

7. Individual #128's brush teeth, and Individual #45's identify his multi vitamin SAP objectives were met, but a new step/objective was not introduced.

8. Additionally, none of the 21 SAPs judged as not progressing (e.g., Individual #92's identify make a bracelet SAP) had evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP).

9. Overall, there was no evidence of data based decisions to continue, discontinue, or modify SAPs for any SAPs.

Outcome 4- All individuals have SAPs that contain the required components.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
13	The individual's SAPs are complete.	0% 0/26	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the 26 SAPs were judged to be complete. A common missing component was the absence of clear SAP training instructions. All SAPs indicated that they utilized forward chaining, backward chaining, total task, or shaping training procedures. None of the SAPs, however, described how to implement these training methodologies. Further, none of the DSPs implementing the SAPs or interviewed by the Monitoring Team understood the differences associated with these different training procedures.

Another common problem was unclear information concerning the current training step. Neither the SAP training sheet nor the SAP data sheet indicated the current training step. Another common missing component was an incomplete maintenance or generalization plan (e.g., Individual #65's identify his medication SAP). Finally, several SAPs (e.g., Individual #133's toothbrushing SAP) specified that formal training would only occur once a week. For many individuals, that frequency of training is likely too infrequent to maximize the acquisition of new skills.

Outcome 5- SAPs are implemented with integrity.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
14	SAPs are implemented as written.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/26	0/3	0/3	0/2	0/3	0/3	0/3	0/3	0/3	0/3

Comments:
14. SAP observations were attempted for several individuals, however, due to individuals not being available, behavioral issues, or concerns associated with the SAPs, the Monitoring Team observed the implementation of only two SAPs. Individual #92 and Individual #128's shredding SAPs were not implemented with integrity. As discussed above, due to unclear instructions, it was not clear exactly how the SAPs were intended to be implemented, however, some obvious integrity issues were evident. For example, Individual #92's SAP indicated that backward chaining should be used, however, the DSP implementing the SAP appeared to be utilizing a version of forward chaining. Similarly, Individual #128's shredding SAP specified a shaping methodology, however, the DSP implementing the SAP appeared to be using total task training.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. At the time of the onsite review, RGSC did not conduct SAP integrity checks. It is suggested that the facility establish a frequency goal of checking the integrity of each SAP at least once every six months.

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
16	There is evidence that SAPs are reviewed monthly.	12% 3/26	0/3	0/3	0/2	0/3	0/3	0/3	3/3	0/3	0/3
17	SAP outcomes are graphed.	88% 23/26	3/3	3/3	2/2	3/3	3/3	0/3	3/3	3/3	3/3

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports, however, many reviews did not include a review of SAP data (e.g., Individual #140's SAPs). Additionally, the most recent SAPs for all individuals other than Individual #150 were dated November 2015, indicating that monthly reviews were not regularly occurring.

17. All SAP data were graphed. Individual #133's SAPs, however, had no data.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
18	The individual is meaningfully engaged in residential and treatment sites.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found one individual (Individual #150) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Rio Grande SC regularly conducted engagement measures in the residential and day treatment sites. The facility established an engagement goal of 80% in all treatment sites. One individual (Individual #150) achieved Rio Grande SC's goal level engagement across both residential and day treatment sites.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-24. There was evidence that all of individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal is achieved. Rio Grande SC did not provide data concerning the implementation of SAPs in the community. SAP training data and a goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
			Individuals:								
#	Indicator	Overall Score	92	65	45	50	140	133	150	128	123
25	The student receives educational services that are integrated with the ISP.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 25. None of the individuals reviewed attended school, so the Monitoring Team reviewed one of the two students at Rio Grande SC, Individual #34, to score this indicator.											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: Based on the documentation available, these indicators were not applicable to any of the individuals the Monitoring Team responsible for reviewing physical health reviewed. However, it was unclear that the Facility submitted/maintained sufficient documentation to conclude that these individuals had not had dental refusals. For example, in the Tier I document request, Individual #50 was on the list of individuals that had refused dental services in the last six months. However, with the documentation the Facility submitted for the Tier II request, no evidence was found of refusals for dental appointments, and/or a plan to address such refusals. This was exacerbated by the lack of annual dental summaries for individuals, which are the documents in which this issue is usually summarized.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	33% 3/9	0/1	0/1	N/A	0/1	0/1	N/A	0/1	2/2	1/2
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	11% 1/9	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/2	0/2

#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
	measurable goal(s)/objective(s).	0/9									
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/2	0/2
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/9	0/1	0/1	N/A	0/1	0/1	N/A	0/1	0/2	0/2

Comments: a. and b. On 3/22/16, Individual #138 had a screening completed. However, this outcome was not assessed for her, because her most recent ISP had not been finalized at the time of the document request (i.e., the meeting was held, but the QIDP was still finalizing the document.)

Some of the problems noted included:

- On 3/15/16, Individual #140 had an annual screening that indicated that she had no communication needs. However, based on the Monitoring Team's interactions with Individual #140, it appeared that, at a minimum, an assessment should have been completed to determine whether or not she would benefit from communication supports and/or services.
- Similarly, on 12/14/15, Individual #79 had an annual screening that indicated that she did not need communication supports. However, based on the Monitoring Team's interactions with Individual #79, it appeared that, at a minimum, an assessment should have been completed to determine whether or not she would benefit from communication supports and/or services.
- Individual #63 should have had a comprehensive assessment to determine her needs, but she did not.
- On 6/26/15, Individual #85 had a screening completed. However, she had a Communication Dictionary, as well as significant communication deficits. A comprehensive assessment should have been done to determine her potential need for communication services and/or supports.
- Individual #29 had communication goals (i.e., related to using his device to access preferred music, and request a drink) that were clinically relevant, but they were not measurable. As a result, the data collected could not be used to measure his progress.
- Individual #97's goal/objective to request a drink was clinically relevant, achievable, and measurable. However, problems were noted with the documentation collected in 2015. Some improvement was noted in early 2016.

c. through e. Individual #138 and Individual #115 did not receive/require communication supports and were part of the outcome sample. Therefore, further review was not conducted for them. For the remaining seven individuals full reviews were completed.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.

			Individuals:								
#	Indicator	Overall Score	140	50	138	79	63	115	85	29	97
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	50% 2/4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/2	1/2

b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									
Comments: Individual #138 and Individual #115 did not receive/require communication supports and were part of the outcome sample. Therefore, the Monitoring Team did not score these indicators for them. a. For Individual #29 data analysis was found in the QIDP monthly reviews in relation to his drink request program, but not for his playing music using a switch program. For Individual #97 data analysis was found in the QIDP monthly reviews in relation to his drink request program, but not for his requesting a ball program.											

Outcome 5 – Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.											
			Individuals:								
#	Indicator	Overall Score	97	29	11	74	62	84	19		
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	71% 5/7	1/1	1/1	1/1	0/1	1/1	0/1	1/1		
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	29% 2/7	1/1	1/1	0/1	0/1	0/1	0/1	0/1		
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/3									
Comments: None.											

Domain #5: Individuals in the Target Population who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and will transition to the most integrated setting(s) necessary to meet their appropriately identified needs, consistent with their informed choice.

Outcomes, indicators, and scores for this Domain will be included in the next Monitoring Team Report.

APPENDIX A – Interviews and Documents Reviewed

Interviews: Interviews were conducted of individuals, direct support professionals, nursing, medical, and therapy staff.

Documents:

- List of all individuals by residence, including date of birth, date of most recent ISP, date of prior ISP, date current ISP was filed, name of PCP, and the name of the QIDP;
- In alphabetical order: All individuals and their at-risk ratings (i.e., high, medium, or low across all risk categories), preferably, this should be a spreadsheet with individuals listed on the left, with the various risk categories running across the top, and an indication of the individual's risk rating for each category;
- All individuals who were admitted since the last review, with date of admission;
- Individuals transitioned to the community since the last review;
- Community referral list, as of most current date available;
- List of individuals who have died since the last review, including date of death, age at death, and cause(s) of death;
- List of individuals with an ISP meeting, or a ISP Preparation meeting, during the onsite week, including name and date/time and place of meeting;
- Schedule of meals by residence;
- For last year, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit);
- For last year, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay);
- Lists of:
    - All individuals assessed/reviewed by the PNMT to date;
    - Current individuals on caseload of the PNMT, including the referral date and the reason for the referral to the PNMT;
    - Individuals referred to the PNMT in the past six months;
    - Individuals discharged by the PNMT in the past six months;
    - Individuals who receive nutrition through non-oral methods. For individuals who require enteral feeding, please identify each individual by name, living unit, type of feeding tube (e.g., G-tube, J-tube), feeding schedule (e.g., continuous, bolus, intermittent, etc.), the date that the tube was placed, and if the individual is receiving pleasure foods and/or a therapeutic feeding program;
    - Individuals who received a feeding tube in the past six months and the date of the tube placement;
    - Individuals who are at risk of receiving a feeding tube;
    - In the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
    - In the past six months, individuals who have had an aspiration and/or pneumonia incident and the date(s) of the hospital, emergency room and/or infirmary admissions;
    - In the past six months, individuals who have had a decubitus/pressure ulcer, including name of individual, date of onset, stage, location, and date of resolution or current status;
    - In the past six months, individuals who have experienced a fracture;
    - In the past six months, individuals who have had a fecal impaction or bowel obstruction;
    - Individuals' oral hygiene ratings;
    - Individuals receiving direct OT, PT, and/or speech services and focus of intervention;
    - Individuals with Alternative and Augmentative Communication (ACC) devices (high and low tech) and/or environmental control device related to communication, including the individual's name, living unit, type of device, and date device received;
    - Individuals with PBSPs and replacement behaviors related to communication;

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
  - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment <u>or</u> refused to allow completion of all or part of the dental exam or work once at the clinic);
  - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
  - In the past six months, individuals with dental emergencies;
  - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
  - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
  - Crisis intervention restraints.
  - Medical restraints.
  - Protective devices.
  - Any injuries to individuals that occurred during restraint.
  - DFPS cases.
  - All serious injuries.
  - All injuries from individual-to-individual aggression.
  - All serious incidents other than ANE and serious injuries.
  - Non-serious Injury Investigations (NSIs).
  - Lists of individuals who:
    - Have a PBSP
    - Have a crisis intervention plan
    - Have had more than three restraints in a rolling 30 days
    - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
    - Were reviewed by external peer review
    - Were reviewed by internal peer review
    - Were under age 22
  - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
  a. PNMT
  b. OT/PT and Speech

c. Medical
d. Nursing
e. Pharmacy
f. Dental

- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical <u>and/or</u> dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:
- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual's transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SOTP	Sex Offender Treatment Program
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus