United States v. State of Texas

Monitoring Team Report

Rio Grande State Center

Dates of Onsite Review: February 27-March 3, 2017

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Table of Contents

Background	3
Methodology	4
Organization of Report	5
Executive Summary	5
Status of Compliance with Settlement Agreement	
Domain 1	6
Domain 2	21
Domain 3	66
Domain 4	111
Domain 5	121
Appendices	
A. Interviews and Documents Reviewed	136
B. List of Acronyms	144

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.
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. **Monitoring Report** – The monitoring 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. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

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. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **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.
f. **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

At the beginning of each Domain, the Monitors provide a brief synopsis of the findings. These summaries are intended to point the reader to additional information within the body of the report, and to highlight particular areas of strength, as well as areas on which Center staff should focus their attention to make improvements.

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Rio Grande SC 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.

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.

This Domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. One of these indicators had sustained high performance scores and will be moved to the category of requiring less oversight. This was indicator 12 (outcome 3) related to restraint.

With the agreement of the parties, the Monitors have largely deferred the development and monitoring of quality improvement outcomes and indicators to provide the State with the opportunity to redesign its quality improvement system. Additional outcomes and indicators will be added to this Domain during upcoming rounds of reviews.

The identification and management of risk is an important part of protection from harm. Risk is also monitored via a number of outcomes and indicators in the other four domains throughout this report. These outcomes and indicators may be added to this domain or cross-referenced with this domain in future reports.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

<u>Restraint</u>
Crisis intervention restraint usage at Rio Grande SC had steadily increased over this and the past two review periods to the point where it was now had the second highest rate (census adjusted) when compare with the other 12 facilities. Further, a high percentage (about half) of crisis intervention restraints were crisis intervention chemical restraints and the average duration of a crisis intervention physical restraint was also the second highest in the state. Typical procedures were not occurring regarding restraint management, such as pre-chemical restraint consultations, documentation of restraint contra-indications in the IRRF, administration of chemical restraint psychiatry protocols, and implementation of actions recommended by the post-restraint review.

The restraint reduction committee was newly formed and not yet accomplishing a typical goal of looking at trends and taking actions. The Center should get guidance from another SSLC that has had more success in restraint (crisis, dental/medical). Staff were very knowledgeable about restraint usage, as evidenced during interviews with the Monitoring Team. This has been the case for some time at Rio Grande SC and resulted in that one indicator moving to the category of requiring less oversight.

Some significant issues were identified with regard to the administration of chemical restraint, including the lack of justification for it, as well as problems with the monitoring of individuals after its administration. Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: providing follow-up for abnormal vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained, for example, with regard to injuries.

<u>Abuse, Neglect, and Incident Management</u>
Rio Grande SC met criteria, and achieved and maintained substantial compliance, such that in August 2015, the Center exited from monitoring of this area, its outcomes, and indicators.

<u>Other</u>
Some IDTs were discussing pretreatment chemical restraint. No IDTs, however, indicated whether treatments or strategies to reduce possible future usage should be implemented and, therefore, treatments or strategies were not implemented in any systematic manner.

The information the Center submitted did not meet the criteria for a Drug Utilization Evaluation (DUE). As discussed in the last report, 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 (P&T) Committee minutes should document presentation of the DUE, recommendations, and a plan of action to address the recommendations. The Center should complete DUEs as the Settlement Agreement requires, and obtain assistance from State Office as necessary.

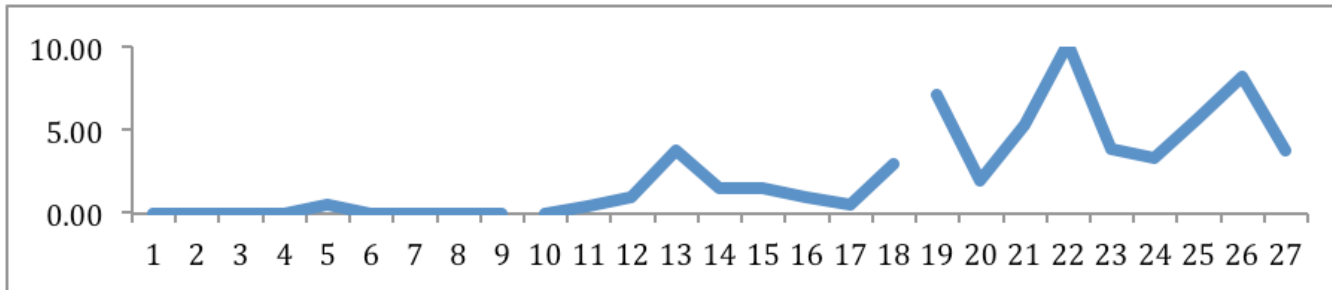
Restraint

<table>
<tr><td colspan="12">Outcome 1- Restraint use decreases at the facility and for individuals.</td></tr>
<tr><td colspan="3">Summary: Crisis intervention restraint usage at Rio Grande SC had steadily increased over this and the past two review periods. A high percentage (about half) of crisis intervention restraints were crisis intervention chemical restraints. The restraint reduction committee was newly formed and not yet accomplishing a typical goal of looking at trends and taking actions. The Center should get guidance from another SSLC that has had more success in restraint (crisis, dental/medical). These indicators will remain in active monitoring.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall Score</td><td>114</td><td>140</td><td>49</td><td>44</td><td>81</td><td>147</td><td>15</td><td>61</td><td>62</td></tr>
<tr><td>1</td><td>There has been an overall decrease in, or ongoing low usage of, restraints at the facility.</td><td>50%
6/12</td><td colspan="9">This is a facility indicator.</td></tr>
</table>

2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1

Comments:
1. Twelve sets of monthly data provided by the facility for the past nine months (May 2016 through January 2017) were reviewed.

Overall, the usage of crisis intervention restraint at Rio Grande SC had increased markedly compared with the last two reviews (see graph inserted below). The census-adjusted rate (the 1000-bed-day calculation), compared to the other 12 facilities, now put Rio Grande as the second highest in the state. Similarly, the frequency of crisis intervention physical restraint and chemical restraint had also increased. The rate of crisis intervention chemical restraint was by far the highest in the state. About 50% of the crisis intervention restraints at Rio Grande SC were crisis intervention chemical restraints. This was the case at the time of the last review, too. Moreover, the average duration of a physical restraint had also increased to the point where it was the second highest in the state, too. The number of individuals who had crisis intervention restraint was also higher, almost twice what it was at the last review.



Some of the data sets showed good performance: there were zero uses of crisis intervention mechanical restraint, no individuals had protective mechanical restraint for self-injurious behavior, and there was but one injury (non-serious) across the entire nine month period.

There were also few occurrences and decreasing trends for the use of restraints (chemical or non-chemical) for medical reasons, and no occurrences of non-chemical restraint for dental procedures. The use of chemical restraint for dental procedures (e.g., sedating medications, general anesthesia) was 13 times in the nine month period, plus about half of the individuals received general anesthesia over the past year. This high rate, combine with the low performance on the PTCR-related outcome in this domain, resulted in this data set not meeting criterion.

Thus, facility data showed low/zero usage and/or decreases in six of these 12 facility-wide measures (i.e., use of crisis intervention mechanical restraints, injuries during restraint, protective mechanical restraint for self-injurious behavior, the use of non-chemical restraint for medical and dental procedures, and the use of chemical restraint for medical procedures).

The Center's restraint reduction committee met for the first time in December 2016 and again during the onsite review (i.e., 3/1/17). The Center had, in the past, had a very low rate of crisis intervention restraint and, therefore, there was not an active restraint

reduction committee. The restraint reduction committee, based on the minutes from the first meeting and observation of the second meeting, requires leadership, a regular agenda, a thorough discussion of trends (e.g., crisis intervention chemical restraints, all of the restraint indicators in this section including those related to nursing, psychiatry, and more than three occurrences in any rolling 30-day period), and development of implementable actions.

The Monitoring Team recommends that the Rio Grande SC get some guidance on the tracking and management of crisis intervention (and medical/dental) restraints from one of the other SSLCs that has been more successfully doing so for some time.

2. Five of the individuals reviewed by the Monitoring Team were subject to restraint. Of these, three received crisis intervention physical restraints (Individual #49, Individual #44, Individual #147), and four received crisis intervention chemical restraint (Individual #140, Individual #49, Individual #44, Individual #61). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for three of the five (Individual #140, Individual #49, Individual #147).

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

Summary: When crisis restraint was used, it was an approved type of restraint, terminated when no longer needed, and injuries did not occur. Many of the other aspects of restraint application required by the indicators in this outcome were not met. Attention should be paid to these basic aspects of restraint management. All of the indicators in this outcome will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	140	49	44	147	61				
3	There was no evidence of prone restraint used.	100% 8/8	1/1	2/2	2/2	1/1	2/2				
4	The restraint was a method approved in facility policy.	100% 8/8	1/1	2/2	2/2	1/1	2/2				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	88% 7/8	1/1	2/2	2/2	1/1	1/2				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 3/3	N/A	1/1	1/1	1/1	N/A				
7	There was no injury to the individual as a result of implementation of the restraint.	100% 8/8	1/1	2/2	2/2	1/1	2/2				
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	88% 7/8	0/1	2/2	2/2	1/1	2/2				
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	Not rated	Not rated	0/2	Not rated	0/2				

10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	38% 3/8	0/1	1/2	1/2	1/1	0/2				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	0% 0/8	0/1	0/2	0/2	0/1	0/2				

Comments:
The Monitoring Team chose to review eight restraint incidents that occurred for five different individuals (Individual #140, Individual #49, Individual #44, Individual #147, Individual #61). Of these, three were crisis intervention physical restraints, three were crisis intervention chemical restraints, and two were labeled as involving both crisis intervention physical and chemical restraint. 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 #61 11/29/16, the 12/1/16 ISPA review noted that the chemical restraint (intramuscular injection) was given when she was already calm and there was no longer any imminent danger. This did not appear to be the case for the other four crisis intervention chemical restraints (based upon review of the ISPAs).

8. For Individual #140 8/6/16, there was confusion between the Center staff and the on-call psychiatrist (the restraint occurred on a Saturday). The documentation said that the on-call psychiatrist said that the use of a medication was not a restraint. The facility QA department told the Monitoring Team that after this occurred, the clinical director talked with all of the on-call physicians regarding the difference in the way medication interventions were classified at the ICF program (as a crisis intervention restraint) compared to the two other mental health programs on campus (not a crisis intervention restraint). That is, that the use of a medication in a crisis situation was a crisis intervention chemical restraint at the ICF program and all crisis intervention restraint related procedures and documentation would need to occur. No documentation about the discussion/training was created at the time, but the facility provided some documentation that was created during the week of the onsite review. There were no further occurrences of this after 8/6/16.

9. Because criterion for indicator #2 was met for three of the five individuals, this indicator was not scored for them. For Individual #44, of the relevant sub-indicators, the PBSP was more than one year old and he was frequently not engaged in any activities. For Individual #61, the PBSP was more than two years old.

10. For the five crisis intervention chemical restraints, the required pre-restraint consultation documentation was not completed. The facility staff said they do make contact, but that they were not aware of the pre-restraint consultation documentation. They said that they will start doing so.

11. The IRRF portion of the ISP, in the behavioral health section, no longer contained the standard templated statement and choices regarding restraint contra-indications.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary: This indicator scored at 100% for this review and for the previous two reviews, too. Therefore, it will move to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	140	49	44	147	61					
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 5/5	1/1	1/1	1/1	1/1	1/1					
Comments: 12. Seven staff who provided direct support to these individuals were interviewed. They were, as a whole, responsive, articulate about restraint, correctly answered the Monitoring Team's questions, and made many positive comments about the individuals, the facility, and their jobs at Rio Grande SC.												

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.												
Summary: Indicator 13 improved from 0% scores during the past two reviews. With sustained high performance, it might move to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	140	49	44	147	61					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 8/8	1/1	2/2	2/2	1/1	2/2					
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	N/A	N/A					
Comments:												

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: Some significant issues were identified with regard to the administration of chemical restraint, including the lack of justification for it, as well as monitoring individuals after its administration. Some of the other areas in which nursing staff need to focus with regard to restraint monitoring include: providing follow-up for abnormal vital signs; providing more detailed descriptions of individuals' mental	Individuals:

status, including specific behaviors observed when agitated as compared to when the individual is calm; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained, for example, with regard to injuries. These indicators will remain in active monitoring.

#	Indicator	Overall Score	140	49	44	147	61				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/8	0/1	0/2	0/2	0/1	0/2				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 2/8	0/1	1/2	1/2	0/1	0/2				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/8	0/1	0/2	0/2	0/1	0/2				

Comments: The crisis intervention restraints reviewed included those for: Individual #140 on 8/6/16 at 8:15 a.m. (chemical); Individual #49 on 8/7/16 at 6:28 p.m., and 8/27/16 p.m. at 8:10 p.m. (physical and chemical); Individual #44 on 11/2/16 at 6:40 p.m. (chemical and physical), and 12/12/16 at 8:49 a.m.; Individual #147 on 8/5/16 at 8:05 a.m.; and Individual #61 on 12/29/16 at 9:45 a.m. (chemical), and 12/3/16 at 1:10 p.m. (chemical).

a. Some significant concerns were noted with regard to the administration of chemical restraints. For example:

- For Individual #140's restraint on 8/6/16 at 8:15 a.m.:
    - The Monitoring Checklist on the Restraint Checklist indicated: Full release-no imminent danger, restraint successfully released. However, the individual was not physically restrained.
    - Nursing staff did not obtain vital signs from 8:45 a.m. to 10:15 a.m., although mental status was noted to be drowsy, calm, and relaxed at times.
    - In relation to ambulation status, the checklist indicated that the individual had "independent ambulation," but also "wheelchair/stretcher" was checked.
    - There were no Integrated Progress Notes (IPNs) after 10:02 a.m. that addressed the individual's status, which would have been necessary, since vital signs had not been obtained as required. An assessment of her status, including a description of her activities during the day of the chemical restraint, should have been included in the nursing documentation, but was not found.
    - The IPN at 10:41 a.m. indicated that at 8:15 a.m., Individual #140 was cooperative for the injection and lay down on her bed to allow nursing staff to administer the injection. Her ability to cooperate indicated that she was not an imminent danger to self or others, which meant that the chemical restraint [Ativan 1 milligram (mg) intramuscular (IM)] was not justified.
    - According to the IPNs, at 11:07 a.m., in response to nursing staff requesting a one-to-one medical supervision protocol order, the physician, physician's assistant, and Executive-on-Call told nursing staff that this was not considered a chemical restraint. Given that it was, the Monitoring Team asked the Center staff for documentation of corrective actions. The Center could not produce any documentation to show that training had been conducted addressing the ICF definition of a chemical restraint and associated procedures.

- All of the questions in the restraint application section of the Debriefing form were completed even though the individual did not have a physical restraint, and some of the questions do no apply to chemical restraint. For example, “yes” was checked for the question: “Was the restraint stopped when the person restrained no longer posed a danger to self or others?” A chemical restraint cannot be stopped once it is administered.

- For Individual #49’s restraint on 8/27/16 at 8:10 p.m.:
  - At 7:30 p.m., the physician ordered Haldol 10 mg, Ativan 1 mg, and Benadryl 50 mg IM STAT, and at 8:12 p.m., ordered Ativan 2 mg IM STAT. These medication orders were not found on the Medication Administration Records (MARs) provided, and no nursing IPNs were found to determine whether nursing staff administered either or both chemical restraints.
  - Nursing staff did not document vital signs and mental status assessments as often as required, or at times, the nurse marked them as “refused.” However, respirations can be obtained without the individual's cooperation. This lack of monitoring was significant, particularly if this individual received two chemical restraints within a short period of time.
- For Individual #44’s restraint on 11/2/16 at 6:40 p.m.:
  - The nurse administering the chemical restraint did a good job including specifics in the IPN about the individual's behavior and the need for a physical restraint to administer the chemical restraint (Haldol 5 mg and Ativan 2 mg IM).
  - However, one IPN at 8:25 p.m. indicated the chemical restraint was given in right dorsal gluteal area and another IPN at 9:33 p.m. noted it was given in left buttock area.
  - Nursing staff indicated that the individual refused two sets of vital signs, but respirations do not require the cooperation of the individual.
  - Nursing staff described mental status as "alert to baseline," which did not provide enough information.
  - The Debriefing Form noted no injury, but then indicated that an injury report was completed. However, none was provided. Other discrepancies on the form related to vital signs, and mental status.
- For Individual #61’s restraint on 12/29/16 at 9:45 a.m.:
  - Based on an IPN at 11:00 a.m. from the nurse that administered the restraint, the chemical restraint (i.e., Ativan 2 mg IM) was not justified. The IPN provided no indication of whether the individual cooperated with the injection, or if staff physically held the individual. Subsequent IPNs from other nurses were entered throughout the day describing the individual's behavior at the time of the chemical restraint, but such IPNs from the nurse who gave the injection were not found.
  - One nursing IPN at 4:18 p.m. gave a specific description of staff holding the individual down with open hands, and noted that a BCBA reported that this was not a physical restraint, but rather response blocking.
  - On 12/1/16, an ISPA meeting was held during which several issues that warranted follow-up were identified, including determining whether Individual #61 was administered a chemical restraint when she was calm. However, the Nurse Case Manager and Nursing Administrators were not aware of the ISPA meeting or the issues identified, and/or any follow-up conducted.
  - Other issues the IDT identified during the ISPA meeting included the need for: 1) the Nurse Case Manager to follow up with the floor nurses, because they should not give Individual #61 items just to avoid a behavior (i.e., nurses were giving her medications outside prescribed timeframes to avoid behaviors); 2) the Nurse Case Manager to follow up to determine if pudding is lactose free according to her diet; 3) Individual #61was to receive Midol four to five days prior

to her menses to address possible agitation, the QIDP was to update the special considerations list with this information, and staff were to be trained, but this was never initiated; and 4) Individual #61 had been drinking sodas and eating fried chicken and Cheetos, but had gastritis and such foods could be causing stomach pain, so the Nurse Case Manager was to retrain staff on her current diet.

- For Individual #61's restraint on 12/3/16 at 1:10 p.m.:
  - No nursing IPN was provided. An IPN from the PCP indicated that Haldol 5 mg and Benadryl 50 mg IM was ordered and given for agitation and banging her head. The PCP note then indicated that after the chemical restraint was administered, the PCP realized that Haldol was on Individual #61's allergy list due to Extrapyramidal symptoms (EPS). The PCP documented monitoring every 15 minutes for one hour with no EPS seen.

For five of the eight restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exceptions were for Individual #140 on 8/6/16 at 8:15 a.m. (chemical); and Individual #61 on 12/29/16 at 9:45 a.m. (chemical), and 12/3/16 at 1:10 p.m. (chemical).

For one of the eight restraints, nursing staff monitored and documented vital signs. This included the restraint for Individual #44 on 12/12/16 at 8:49 a.m.

Nursing staff documented and monitored mental status of the individuals for two of the eight restraints. For example, for Individual #49's restraint on 8/7/16, the nursing IPN was very detailed regarding the individual's behavior before and after the restraint. For Individual #147's restraint on 8/5/16, the nurse also did a good job documenting his mental status assessments. However, in some instances, sufficient description was not provided of the individual's mental status (e.g., "awake and alert").

b. For Individual #49's restraint on 8/27/16 at 8:10 p.m., the physician's IPNs noted bruising to the individual's left shoulder and scratches to the right shoulder. However, the Restraint Checklist forms indicated no injuries, and the Center provided no nursing IPNs to determine if the injuries the physician cited were from restraint procedures.

After Individual #147's restraint on 8/5/16 at 8:05 a.m., an IPN noted redness with a scratch to the individual's right elbow, and five on a one to 10 scale of pain. However, it was unclear if this injury happened during the restraint process. Further, an IPN at 10:59 a.m. noted the individual received Tylenol 650 mg for pain (five on a one to 10 scale) to his right elbow after a horizontal restraint in the morning. At that time, nursing staff documented no assessment of the individual's elbow. The Restraint Checklist noted no injury.

c. For Individual #49's restraint on 8/7/16, his pulse was 104, and the nurse should have retaken it, but did not.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

Summary: Correct documentation in the required format improved from the last review. With sustained high performance, it might move to the category of requiring less oversight after the next review. It will remain in active monitoring.

#	Indicator	Overall	Individuals: 140	49	44	147	61				

		Score									
15	Restraint was documented in compliance with Appendix A.	100% 8/8	1/1	2/2	2/2	1/1	2/2				
	Comments:										

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.											
Summary: Documentation showed review of restraints (though some onsite interviews indicated that these did not always occur when the team was meeting in vivo). Recommendations from these reviews were, for the most part, not implemented. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	49	44	147	61				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 8/8	1/1	2/2	2/2	1/1	2/2				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	29% 2/7	0/1	0/1	0/2	1/1	1/2				

Comments:

17. Post-restraint ISPAs contained some good information and all contained from one to four recommendations. Documentation of implementation was not provided prior to the onsite review, but while onsite, the Monitoring Team requested any relevant documentation. As a result, one of the investigations for Individual #147 and one for Individual #61 met criterion. For the other five:

- Individual #140 8/6/16: one of the two recommendations was implemented.
- Individual #49 8/7/16: neither of two recommendations were implemented.
- Individual #44 11/2/16: the one recommendation to complete a crisis intervention plan was completed, but not until 3/2/17.
- Individual #44 12/12/16: none of the four recommendations were implemented.
- Individual #61 11/29/16: two of the four recommendations were not implemented.

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.)											
Summary: The requirements for these indicators require additional attention in order to move towards meeting criteria. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	49	44	61					
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/4	0/1	0/1	0/1	0/1					
48	Multiple medications were not used during chemical restraint.	50% 2/4	1/1	0/1	0/1	1/1					

49	Psychiatry follow-up occurred following chemical restraint.	0% 0/4	0/1	0/1	0/1	0/1					
Comments: 47-49. These indicators applied to chemical restraints for four individuals. In two cases, Individual #49 and Individual #44, more than one medication was administered. Individual #49 received three medications and Individual #44 received two medications. The Administration of Chemical Restraint: Consult and Review was not performed within the 10-day time frame for any of these four restraints. There was no documentation of psychiatric follow-up following the restraint episode.											

Abuse, Neglect, and Incident Management

Rio Grande SC met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management in August 2015. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain under active monitoring.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/3	N/A	0/1	N/A	N/A	N/A	N/A	0/1	0/1	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/2	0/1	0/1					N/A	N/A	
Comments: a. The Center did not have a policy that included dental and/or behavioral criteria for selection of individuals for TIVA. The Center was using a form from the hospital that described the necessary pre-operative evaluations. Thus, there was a process to ensure that the PCPs or other specialists conducted an adequate pre-operative evaluation for individuals administered TIVA, which was good to see. With regard to informed consent, the Center Director signed a form that purportedly provided the RN Case Manager permission to provide informed consent on the individuals' behalf. It was unclear that this authority could be delegated. Moreover, the Center did not provide copies of actual informed consents for the procedures. b. For Individual #15 and Individual #61, pre-procedure and post-procedure vital signs were documented. 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.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/4	0/2	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. On 8/2/16, Individual #15 had pre-treatment sedation for a hearing appointment, and on 8/24/16, he had it for a dermatology appointment. On 7/5/16 and 7/25/16, Individual #61 was administered pre-treatment sedation for brain magnetic resonance imaging (MRI). For none of these instances of medical pre-treatment sedation did the Center provide documentation to show that informed consent was obtained, or that the PCP had determined the medication and the dosage range with input from the IDT. On a positive note, pre-procedure vital signs were documented for all instances. Post-procedure vital signs were documented for all instances except for Individual #15 on 8/2/16.											

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.											
Summary: IDTs met the requirements of the first indicator for two of the four individuals. But IDTs did not determine whether action plans should be developed or whether they were counter-therapeutic. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	15	61	62					
1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	50% 2/4	0/1	0/1	1/1	1/1					
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.	0% 0/4	0/1	0/1	0/1	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	0% 0/4	0/1	0/1	0/1	0/1					

#	Indicator	Overall Score									
	ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										
4	Action plans were implemented.	0% 0/4	0/1	0/1	0/1	0/1					
5	If implemented, progress was monitored.	0% 0/4	0/1	0/1	0/1	0/1					
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/4	0/1	0/1	0/1	0/1					

Comments:
1-6. Four individuals received PTCR since the last review.

Individual #15 received PTCR on 8/2/16 (for a hearing exam), 8/24/16 (for dermatology exam), 8/29/16 (for a dental exam), and 10/17/16 (for transportation to the hospital for low sodium levels). The 10/17/16 occurrence was found in the ISPA, the others in medical restraint documentation. PTCR effectiveness in the past was generally discussed in the most recent ISP. For all occurrences, behaviors observed during the procedure and risks/benefits of PTCR were discussed. None, however, included ideas of procedures that could be considered in the future, or informed consent for PTCR.

Individual #61 received PTCR for dental work on 8/15/16, and for an MRI on 7/25/16. The IDT identified the need for PTCR for both procedures in two separate ISPAs.

Individual #62 received PTCR on 9/1/16 for a dental exam. The need for PCTR was documented in two ISPAs and in medical restraint documentation.

Individual #140 received PTCR for dental procedures on 10/20/16 and 12/7/16. The IDT met on both occasions and determined the PTCR was necessary given Individual #140's past behaviors during dental exams. However, there was no evidence of consent.

Because indicator 2 was not addressed, the subsequent indicators were also scored at 0%.

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.

Summary: The Monitoring Team will continue to assess these indicators.

#	Indicator	Overall Score	Individuals:								
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	N/A									

	extension with justification, and the administrative death review is completed within 14 days of the clinical death review.										
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	N/A									
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	N/A									
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	N/A									
e.	Recommendations are followed through to closure.	N/A									
Comments: a. According to documentation the Center provided, since the last review, none of the individuals at Rio Grande State Center had died.											

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	ADRs are reported immediately.	0% 0/3	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/3	0/1	0/1							0/1
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/3	0/1	0/1							0/1
d.	Reportable ADRs are sent to MedWatch.	0% 0/3	0/1	0/1							0/1
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed. In fact, in the six months prior to the review, based on the documents submitted, staff had not reported any ADRs for any of the individuals in the ICF program at Rio Grande. However, given that in its review of records, the Monitoring Team identified potential adverse drug reactions, the Center's surveillance and reporting system for adverse drug reactions appeared to require improvement. The following provide potential adverse drug reactions should have been reported:											

- The long-term use of nitrofurantoin was discontinued for Individual #108, and cited as a possible etiology of pulmonary fibrosis. However, this did not appear to result in an ADR report.
- On 10/20/16, a post-hospital assessment also noted that Individual #15's hypertension was stable on enalapril 40 mg each day. On 10/21/16, the PCP conducted follow-up to assess the individual who had a BP of 70/42, and pulse of 90. This was attributed to the change in enalapril dose that was 20 mg by mouth BID prior to hospitalization. There was no further follow-up related to the blood pressure.
- The quarterly medical summary for Individual #61 for January 2017 documented that Trileptal was being tapered due to hyponatremia. This was a potential adverse drug reaction, but was not reported as such.

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.		
Summary: For this review and the last one, documentation the Center provided did not meet the definition of a DUE. The Center should complete DUEs as the Settlement Agreement requires, and obtain assistance from State Office as necessary. These indicators will remain in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/1
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/1

Comments: a. As discussed in the last report, 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 P&T Committee minutes should document presentation of the DUE, recommendations, and a plan of action to address the recommendations. The information the Center submitted did not meet these criteria. More specifically:

- The Center submitted a document entitled medical staff summary, DUE Invega Sustena for March 2016 through May 2016. This was not an appropriately completed DUE, and it could not be determined who submitted it. There were a series of unexplained charts and a several pages showing a list of indications. There was no narrative and no P&T minutes to explain any of this information.

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.

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.

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Six of these indicators, in psychiatry and behavioral health, medical, and dental will be moved the category of requiring less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Assessments

Assessments that were needed were considered and identified by the IDTs for all individuals. But, also for all individuals, assessments were not always obtained prior to the ISP meeting.

For the individuals' risks reviewed, few of the IDTs effectively used supporting clinical data (including comparisons from year to year), and used the risk guidelines when determining a risk level. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

Although some additional work was needed, the Center made progress with regard to the quality of medical assessments. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe family history, and childhood illnesses.

The Center needs to focus on the timeliness, as well as the quality of dental exams and summaries. As is discussed in further detail below, the Center should work with the community dentist to ensure that required documentation is provided in a format that is useful to the Center, and particularly individuals' IDTs.

Generally, annual comprehensive nursing assessments were completed timely. However, they 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.

Four of the individuals reviewed should have had Physical and Nutritional Management Team (PNMT) review and/or a comprehensive assessment, but did not. It is important that the Center have systems in place for IDTs to make referrals when individuals meet criteria for PNMT referral, and for the PNMT to self-refer should IDTs fail to do so. In addition, for the one individual reviewed for whom a comprehensive PNMT assessment was conducted, a number of problems were identified. Improving the quality of the PNMT assessments will require the PNMT to involve the disciplines necessary to assess and address the etiology of the individual's physical and nutritional management issues.

The Center should focus on the timeliness as well as the quality of OT/PT assessments and updates.

During this review and the past one, the communication updates showed some good improvement in quality, but more work was needed to ensure updates thoroughly addressed all of the necessary components. Timeliness also was improving, but needed continued focus.

Much like the other SSLCs, there were no individualized psychiatric goals for individuals. Because Rio Grande SC does not have access to the SSLC electronic health record (IRIS), they will need to obtain and include the psychiatric goals grid being utilized by the other facilities. All individuals had a CPE and this was the case for this review and the last two reviews, too (with one exception in August 2015). Some attention to format and inclusion of all required content categories was needed. Annual psychiatry updates/evaluations, when done, met all of the criteria. More than half of the individuals, however, did not have psychiatry updates/evaluations completed (though this was an improvement since the last review).

Individuals had PBSPs, and they had goals that were measurable and that were based upon assessments. But without reliable data, all of this work can not come to fruition because IDTs, behavioral health services, clinical staff, and facility management can not really know if individuals are progressing or not.

Most of the annual assessments needed to include recommendations for SAPs. This may set the occasion for the IDT to develop more SAPs that are relevant for the individual's life.

<u>Individualized Support Plans</u>
The development of individualized, meaningful personal goals was not yet at criteria, but much progress was evident. Five of the six ISPs, for instance, included at least one goal that met criteria, and three ISPs had goals that met criteria in five of the six areas (i.e., all except health/wellness IHCP goals). More than half of these 17 goals were written in measurable terms, also demonstrating good progress. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress. When considering the full set of ISP action plans (outcome 3), the 11 indicators were not met. That being said, five of the 11 indicators showed some improvement since the last review.

ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Progress and implementation were not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken.

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing, and physical and nutritional support interventions. However, on a positive note, six of the 18 IHCPs reviewed included ongoing nursing assessments and interventions that were consistent with current standards of practice. This was a very positive change, and the Center is encouraged to continue and expand its efforts to improve the quality of IHCPs.

The psychiatrist was highly involved with all individuals, but even so, completion of the annual update is an important aspect of the information that IDTs need to consider in creating the overall annual ISP.

A third of the individuals did not have current (written/revised in the last 12 months) PBSPs. About a third of the PBSPs did not contain all of the required components.

Each individual had SAPs, though three individuals had less than three SAPS, which was surprising given their many skill needs. Most SAPs were written in measurable terms, which was good to see, but many were not based on assessment results and/or were not practical, functional, or meaningful for the individual. Recent changes in SAP management and organization provide some optimism that the quality of SAPs could improve by the time of the next monitoring review.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. Five of the six ISPs, for instance, included at least one goal that met criteria, and three ISPs had goals that met criteria in five of the six areas (i.e., all except health/wellness IHCP goals) for a total of 17 goals that met criteria. This was very good progress since the last review. More than half of these 17 goals were written in measurable terms, also demonstrating good progress. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			

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	5/6	5/6	0/6	1/6	5/6	1/6			
2	The personal goals are measurable.	0% 0/6	2/6	1/6	0/6	1/6	5/6	1/6			
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 #147, Individual #140, Individual #15, Individual #61, Individual #48, Individual #27). 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.

The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. 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 need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

None of the six individuals had individualized goals in all areas, therefore, none had a comprehensive set of goals that met criterion. The Monitoring Team did, however, identify good progress in the development of personal goals that were aspirational and reflective of individualized preferences and strengths, as described below.

1. It was an indicator of progress that the IDTs had defined some personal goals that were individualized and clearly based on the individual's preferences and strengths. Overall, 17 personal goals met criterion for this indicator. These included:

- Individual #147's goals for leisure/relationships, employment, independence, and living options.
- Individual #140's goals for leisure/relationships, employment, independence, and living options.
- Living options goals for Individual #61 and Individual #48.
- Individual #27's goals for leisure, relationships, employment, independence, and living options.

For some others, the goals appeared to meet criterion on the surface, but this did not hold up when scrutinized. For example, for Individual #48, the IDT developed a series of goals for leisure and relationships that focused on his volunteering at an animal shelter. The evidence provided did not indicate that he had a specific interest in animals or had ever been around them. The IDT did not develop an ISP Preparation action plan to test his reaction to being around animals prior to the ISP annual meeting; rather the IDT waited to create an action plan at the ISP annual meeting to introduce him to a variety of animal/pet stores to test his motivation to

volunteer and participate at an animal shelter. This action plan, in turn, did not specify a completion date before 7/1/17, which would make implementation of any opportunity to volunteer virtually impossible within the year. In any event, the IDT did not implement that action plan. The Monitoring Team attended his ISP Preparation meeting and the IDT agreed to abandon these goals without addressing why no progress was made or whether the goal may have been meaningful to him. Instead, the IDT agreed to replace this leisure goal with placing third in the Special Olympics 100-meter walk. All goals related to the animal shelter were discontinued.

Other goals failed to define an outcome that was aspirational. More often they appeared to be action plans that might be related to a more aspirational outcome, but the IDT did not specify what that might be. For example, for Individual #147, the IDT developed a leisure goal in 2016 for him to participate in Special Olympics bowling team. He successfully participated as a member of the bowling team, placing fifth in the state. For the 2017 ISP attended by the Monitoring Team, the IDT developed a goal for him to be a member of the Special Olympics Track and Field team. Given that Individual #147 hopes to live in the community in his own apartment, the IDT should have also considered developing a leisure goal that would assist him to achieve community integration. In this case, his success with bowling could have been expanded into joining a community bowling league.

In September 2016, the Center had begun a Good Goals pilot to address these issues related to the development of individualized, functional, and meaningful goals. The Monitoring Team attended a Good Goals meeting while onsite to observe the process and believed it held promise for improving the development of truly meaningful and functional personal goals. The Monitoring Team also suggested to the Center some additional process improvements:

- QIDPs could use this process to begin to engage the rest of the IDT in the goal development process, such as inviting habilitation therapists to participate in Good Goals meetings when individuals have significant physical and nutritional management needs.
- QIDPs could use the summary sections of the PSI to synthesize the preferences and strengths to help the IDT envision the rationale for the proposed goals, rather than just listing a set of bullets. In other words, tell the story in a manner that allows the IDT to see the big picture.
- QIDPs could use the tentative goals sections to lay out, at least, a broad road map for how a goal will be reached over time. For example, one individual had a goal to get his driver's license. The IDT should project a set of logical and sequenced action plans for goal attainment. In this case, that might begin with the current need to obtain and review the drivers' manual, to successfully obtaining his learner's permit, to taking drivers' education, to passing his drivers' license exam. Each of these steps could include an estimate of the time it might take. This also allows the IDT to envision how an aspirational goal might be achieved and how long it might take.
- When possible, the IDT should consider avoiding "one and done" goals that don't have ongoing application for the individual's vision for his/her future life. One example was Individual #147's goal, as described above. Instead, the IDT might have built upon his bowling prowess to develop longer term goals for relationships and leisure time in the community through perhaps joining a bowling league. Likewise, at the Good Goals meeting, the IDT proposed a goal for another individual to read the Twilight series, an activity he had already begun, but was struggling with due to unfamiliar vocabulary. Reading the series and using a dictionary to look up words he didn't know were good action plans, but perhaps an even better overall goal would have been to learn to read at a 6th grade level. This would have more long term application.

2. Of the 17 personal goals that met criterion for indicator 1, 10 met criterion for measurability. This also indicated progress being

made by the Center, that is, in terms of structuring how goals were written. These goals included:

- Five of Individual #27's goals, for leisure, relationships, employment, independence, and living options.
- Two of Individual #140's goals, for independence and living options.
- Individual #147's goal for relationships.
- Living options goals for Individual #61 and Individual #48.

3. For the 17 personal goals that met criterion in indicator 1, it was disappointing that none had reliable and valid data. The QIDPs had not been consistently monitoring ISPs. Monthly QIDP reviews were virtually non-existent for the past nine months. Those that were available for review, primarily for August 2016 and September 2016, had been completed in mid-January 2017, so even these had not been used for timely monitoring. The Center had contracted with an individual to complete all the backlogged QIDP monthly reviews, which was still underway. QIDPs should be taking responsibility for routine monitoring going forward, beginning immediately. The remaining personal goals did not meet criterion above, therefore, there was no basis for assessing whether reliable and valid data were available to determine if the individual met, or was making progress towards achieving, his/her overall personal goals.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.											
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met. That being said, five of the 11 indicators showed some improvement since the last review. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	0/6	0/6	3/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	0/1	1/1	0/1	0/1	1/1	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.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
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.	33% 2/6	0/1	1/1	0/1	0/1	1/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	1/1	0/1	0/1	1/1	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.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/5	0/1	0/1	0/1	0/1	N/A	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:
As Rio Grande SC further develops more 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. The Monitoring Team found Individual #27's ISP to be the most successful in defining action plans that clearly supported personal goals. These included supporting action plans for leisure, relationships, and independence. Otherwise, ISP goals did not have a clear set of action plans that would serve as a road map for their ultimate achievement. Action plans were often very preliminary. The IDTs did not yet use the ISP Preparation meeting process to explore and examine their proposed goals to address these preliminary needs. The Monitoring Team found it concerning that this lack of action by the IDTs tended to result in an entire year of opportunities for learning and growth lost in these individuals' lives. For example:

- For Individual #48, the IDT developed a series of goals this last year for leisure and relationships that focused on his volunteering at an animal shelter.
  - The evidence provided did not indicate that he had a specific interest in animals or had ever been around them.
  - The IDT did not develop an ISP Preparation action plan to test his reaction to being around animals prior to the ISP annual meeting; rather the IDT waited until the ISP to create an action plan to introduce him to a variety of animal/pet stores and the different types of pets available to test his motivation to volunteer and participate at an animal shelter. This action plan, in turn, did not specify a completion date before 7/1/17, which would make implementation of any opportunity to volunteer virtually impossible within the year. In any event, the IDT did not implement that action plan at all.
  - The Monitoring Team attended his ISP Preparation meeting for the coming year and the IDT agreed to abandon these goals without addressing why no progress was made or whether the goal may have been meaningful to him. Instead, the IDT agreed to replace this leisure goal with placing third in the Special Olympics 100-meter walk. All goals related to the animal shelter were discontinued.

9. The Center had made some progress in the integration of preferences and opportunities for choice in the identification of personal goals for the ISPs. ISPs for Individual #147 and Individual #27 met criterion for this indicator. In addition, as described above under

Indicator 1, the Good Goals process focused on development of a meaningful, individualized, and comprehensive PSI as the foundation for establishing goals and action plans. Otherwise, the IDTs had not yet consistently integrated preferences and strengths into the action plans, even when the personal goals themselves did reflect those components. Examples of concerns included:

- While 2016 goals reflected Individual #140's apparent strengths and preferences, the action plans themselves provided little real opportunity to exercise those strengths and preferences. For example, her leisure goal to volunteer at zoo had an action plan to be assessed for being around animals, but none for any action to be taken based on the assessment. The action plans for working at a western wear store were only to refer to the Department of Assistive and Rehabilitative Services (DARS) and to point to Clozapine. The action plan for making a friend at the zoo had an action plan to visit the zoo, but required only that it be done once.
- Individual #15's ISP integrated minimal preferences. The Psychiatric Nursing Assistant (PNA) who worked with him indicated he liked choosing his own clothing. The IDT could have incorporated this into an action plan, but did not.
- Individual #61's ISP integrated minimal preferences. Her Preferences and Strengths Inventory (PSI) offered many options, such as learning to swim, an arts and crafts group, and liking to help others with tasks, but the ISP integrated none of these.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for any of the six individuals. No action plans were identified that clearly supported decision-making skills. Other examples of concerns included:

- Individual #147's Individual Capacity Assessment (ICA) indicated that he could make decisions, but the IDT later decided this was not the case because he made decisions that the IDT felt were not in his best interests. This indicated a need for a more thorough assessment. The IDT did suggest in an ISPA that the ICA should be reviewed, but no evidence indicated this had been completed.
- Individual #61 had one skill acquisition plan (SAP) to identify healthy foods, which may have had potential to lead toward decision-making. This was not incorporated into the methodology for the SAP.

11. The ISPs for Individual #48 and Individual #27 met criterion for this Indicator. Individual #48's action plans included beginning to use a visual icon schedule at work as a first step toward using a picture schedule at the animal shelter and held promise for enhancing communication in other areas of daily life. He had additional SAPs for communication, paying for purchase, and toileting hygiene. Individual #27 was already very independent and action plans supported enhancing her ability to be more independent in activities of daily living and engage in the community. Otherwise, action plans did not assertively promote enhanced independence for other individuals. Examples included:

- The IDT did not emphasize skill acquisition for Individual #147. His action plans included no skill acquisition, except one to identify a medication. His vocational action plan focused only on compliance with attendance and not what he might learn there. He aspired to live in his own apartment, but the IDT developed no action plans for skills needed to support that goal.
- Individual #61's PSI identified many opportunities to enhance independence, including brushing her hair, tying her shoes, changing TV channels, and using phone independently. The IDT did not address any of these.
- Individual #140's ISP included three action plans for additional independence: to cut her own meat and floss and brush her teeth. In the last QIDP monthly review for July 2016 (completed 9/5/16), all three were to be discontinued. The plan to cut her meat was discontinued due a diet downgrade, while the other two were discontinued because she had those skills and needed a compliance plan instead. The IDT had not proposed or implemented any additional skill acquisition.

12. IDTs did not consistently integrate strategies to minimize risks in ISP action plans.
- IDTs did not consistently address falls risk as needed. For example:
  - On 11/4/16, the IDT for Individual #15 met to discuss three falls within 90 days. These falls occurred on 8/26/16, 10/11/16, and 10/29/16. The IDT determined at that time that no further recommendations were needed because the falls were due to medical issues that had been addressed and to a fall when he missed the edge of sidewalk and fell. The IDT did not document the falls precautions that were in place at that time. Since the 11/4/16 ISPA, he had another three falls within an ensuing 90-day period, on 11/5/16, 1/6/17, and 1/10/17. These falls occurred despite one to one supervision to prevent falls. The IDT had not met again to review the continuing falls or complete a thorough falls assessment.
  - Individual #140, Individual #61, and Individual #27 all had continuing falls, without a comprehensive falls assessment completed.
- IDTs did not consistently address weight issues.
  - Individual #48 had been experiencing a significant weight loss, which was described as seeming to be slow and unexplained. The IHCP action plans were limited to recording monthly weights and intake. It provided no criteria requiring review.
  - For Individual #147's risk related to weight, the IHCP had action plans for a low-fat diet and snacks and to record weight monthly, but provided no criteria that would trigger additional review. The IDT did not address an exercise action plan.

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, examples included:
- IDTs did not consistently address dental risks in an assertive manner.
  - Individual #61 was at high risk for dental health. Per the IRRF, she needed to be referred to the Board-Certified Behavior Analyst (BCBA) for refusals of appointments and for dental rehearsals. No action by BCBA was documented. The Positive Behavior Support Plan (PBSP) was from 2014.
  - Individual #27 was at medium risk for dental health. The IHCP indicated Individual #27 had a SAP for hand-over-hand toothbrushing. The ISP stated the IDT declined to include that SAP and instead developed a service objective (SO) for ensuring she brushed daily. It did not seem likely daily brushing, instead of two or three times daily, would be sufficient to address this risk.
- Individual #15's ISP included an action plan to contact DARS to inquire about services for the visually impaired. This action plan described no specific outcome for Individual #15. The IDT should have contacted DARS between the ISP Preparation meeting and the ISP annual meeting, so they could have developed a specific outcome-oriented goal at the ISP. At his ISP Preparation meeting for 2017, attended by the Monitoring Team, the IDT indicated that DARS would not offer services to individuals living at Center, but the IDT did not address how it might address his visual needs in an alternative manner, such as an orientation and mobility assessment or a specialized OT assessment focused on needs for individuals with low vision. The IDT only requested an OT screening.

14. The ISPs for Individual #147 and Individual #27 both had action plans that met criterion for this indicator; it was unfortunate they had not been implemented consistently, if at all. Meaningful and substantial community integration action plans were largely absent from the remaining ISPs, with no specific, measurable action plans for community participation that promoted any meaningful integration.

15. Two of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Individual #147's ISP had action plans to obtain employment at the Game Stop store as well as related action plans to be evaluated for dentures, to have a hand assessment by the occupational therapist, to pick up job applications, and to address behavioral barriers to employment. Individual #27's ISP also included action plans to advance her goal for working at the Hobby Lobby store. It is important to note here that these promising action plans met criterion for having been developed, but had not been implemented to any degree. The remaining ISPs minimally addressed vocational and day programming needs. Examples included:

- Individual #15's ISP included a very broad goal to attend vocational classes that would provide him with activities to enrich his day. The only action plan was staff to encourage him to attend vocational programming to engage in activities offered there.
- Individual #61's PSI indicated staff felt she would be good at being an office assistant because she liked to relay communications between people, help people with tasks, and greet people. It also noted she was a hard worker and would be good at cleaning, organizing, and sorting. The IDT did not address these with action plans.
- Individual #140's goal reflected day programming/employment in an integrated setting, but the related action plans did not support the achievement of that goal. The IDT did not develop other action plans for employment or day program at the Center. Her daily schedule included attending vocational programming, but the ISP did not include action plans describing how she would be meaningfully engaged there.

16. Two of six ISPs, for Individual #48 and Individual #27, 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. Vocational activities and/or skill acquisition opportunities were particularly lacking overall for other individuals (also see skill acquisition indicator 18).

17. The IDT did not consistently address barriers to achieving goals. The Monitoring Team was particularly concerned that some individuals had goals continued from one ISP to another without having made any progress, but the IDT failed to examine how to address the related barriers or how to resolve them to achieve a more positive outcome. For example, Individual #147 had goals for 2016 to get a job at Game Stop and to attend college classes. Action plans for these had not been implemented. The IDT continued these for his 2017 ISP without identifying or addressing the barriers that resulted in this failure. In several instances, it was the inaction on the part of the IDT that was the likely obstacle. It was incumbent upon the IDT to recognize this and take assertive action to correct it.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. SAPs were often missing key elements, as described elsewhere in this report. Living options action plans often had no measurable outcomes related to awareness.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.											
Summary: Criterion was met for some indicators for some individuals, and the scores for three indicators improved from the time of the last review, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. Primary areas of focus are reconciliation of team member recommendations for referral, and the conduct of a thorough living options discussion. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
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	0/1	0/1	0/1	1/1	1/1			
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.	100% 1/1	N/A	1/1	N/A	N/A	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	0/1	1/1	1/1	0/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	N/A	1/1	N/A	N/A	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% 0/5	0/1	0/1	0/1	0/1	0/1	N/A			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A			
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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	0/1			

Comments:
19. Two of six ISPs included a description of the individual's preference and how that was determined. Individual #48's IDT identified specific preferences that supported the determination for living options, discussed his awareness, and made several specific recommendations about his needs for community education. Individual #27 had toured living options, attended provider fairs and completed two pre-placement visits. She stated she preferred to remain at RGSC and confirmed this in interview. It was not clear if she had been engaged in a conversation about the option to move to Colorado to be near her sister, but the IDT did suggest this as a possibility. Examples of ISPs that did not meet criterion for this indicator included:

- Individual #61 had no exposure to living options. The IDT did not document any discussion of what types of living options might fit her specific needs. The ISP Preparation meeting defined a tentative goal to move to a group home, but the IDT neither prescribed nor took any action before the ISP to attempt to explore her preferences.
- Individual #140 informed the LIDDA worker she wanted to live in San Antonio with peers in an apartment, but the IDT believed she would prefer to live closer to her family in Brownsville and established that as the goal. The IDT did not document how or if they explored Individual #140's stated preference.
- Individual #147's ISP indicated he stated he wanted to live in an apartment, but later clarified he meant assisted living. The ISP included no additional detail, discussion, or exploration about what that meant.

20. The Monitoring Team observed Individual #147's annual ISP meeting. The IDT provided a description of where he wanted to live based on his stated preferences for his desire to live in an apartment by himself. He had previously lived in group homes and explained that he did not have good experiences there. The IDT identified that he had good awareness of his living options.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members. Current assessments by key staff members were sometimes not available at the time of the ISP. Those that were present sometimes provided a statement of the opinion and recommendation of the respective team member, but this was not consistent. The IDT did not always make a statement and offer a recommendation regarding living options that was consistent. Examples included:

- The physical therapist (PT) and Speech-Language Pathologist (SLP) indicated Individual #140 could be served in the community and made this recommendation. The statement in the ISP indicated all IDT members in attendance agreed not to refer because she was not behaviorally/psychiatrically stable. The IDT provided no documentation as to how the IDT resolved these differing opinions.
- The following assessments indicated Individual #61 could be served in the community and so recommended: nursing, nutrition, and the functional skills assessment (FSA). The medical, psychiatry, vocational, and PT assessments did not recommend community living and the behavioral health, dental, and SLP assessments were not documented. The statement indicated all IDT members in attendance agreed not to refer because of challenging behaviors, but provided no documentation of how the IDT resolved these differing opinions.

22. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for none of six individuals. The Monitoring Team based this assessment on the lack of documentation of team input and/or team consensus and resolution among the opinions of various members.

23. One of six individuals (Individual #48) had a thorough examination of living options based upon their preferences, needs, and strengths. Examples of those that did not included:

- The IDTs for Individual #61 and Individual #15 documented no discussion of various living options that might meet their needs.
- Individual #140's IDT discussed she had toured living options in the past, but documented no real discussion of her level of awareness and how that might have played in to her stated preference for living in San Antonio versus the IDT's determination for living in Brownsville.
- The IDT discussed Individual #147's previous experience with community living, but did not document any discussion of the reasons it had not been successful, other settings that might be appropriate, or his preference for and potential for success in apartment/assisted living

24. Four of six ISPs, for Individual #147, Individual #15, Individual #48, and Individual #27, identified a thorough and comprehensive list of obstacles to referral in a manner that should allow for the development of relevant and measurable goals to address the obstacle. Examples of those that did not meet criterion included:

- For Individual #140, the IDT identified behavioral/psychiatric needs, but did not identify individual choice/awareness as needed.
- Individual #61's IDT identified, but did not select an obstacle. It did document challenging behaviors as a barrier in the narrative, but did not select that or her lack of individual awareness.

25. The Monitoring Team observed Individual #147's ISP annual meeting while onsite. The IDT did develop a comprehensive list of potential barriers.

26. Individual #48's IDT indicated he would be referred. None of the remaining five individuals had individualized, measurable action plans to address obstacles to referral. Examples included:

- For Individual #15, the only action plan was to tour group homes until completed. The action plan included no frequency, learning objectives, data collection methodology, or plan for evaluation.
- Individual #140's IDT defined a behavioral/psychiatric barrier, with an action plan for the psychiatrist to continue to follow her progress and adjust her medication as needed to stabilize her. The IDT provided no criteria for how stabilization would be defined or any specific documentation methodology.

27. The Monitoring Team observed Individual #147's annual ISP meeting. Action plans that addressed his awareness and learning needs regarding community living were not clearly spelled out. The IDT discussed the need to commit to implementation of token economy, but did not have discussion of what criteria needed to be met for community living to be considered. The IDT did not have a specific discussion about examining or exploring various living options.

28. None of six ISPs had individualized and measurable plans for education. For Individual #48, it was particularly disappointing that the IDT's action plan was generic (provide group home tours) despite good discussion documented at the meeting.

29. Five of six individuals had obstacles identified at the time of the ISP. The IDT for Individual #48 identified no obstacles and indicated he should be referred. It did not develop an action plan to refer, there was no documentation available the referral occurred, and he was not included on the Center's current referral list.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were revised annually, but not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
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	0/1	0/1	1/1	1/1			
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. ISPs were implemented on a timely basis for none of six individuals. As described throughout this section, the Center had engaged in minimal implementation of ISP action plans in this review period.

33. Three of six individuals participated in their ISP meetings. Both Individual #147 and Individual #27 were knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP.

34. None of six individuals had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Examples of those did not included:

- No dental staff attended Individual #147's ISP, but he had significant dental concerns at the time, including the potential removal of his remaining two teeth. The OT/PT did not participate, but Individual #147 required assessments for hand use and ankle-foot orthoses (AFOs.)

- Individual #15's ISP did not include representation from behavioral health, habilitation therapies, vocational or day/retirement program, or a PNA.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Assessments that were needed were considered and identified by the IDTs for all individuals. But, also for all individuals, assessments were not always obtained prior to the ISP meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
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.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
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 all six individuals. It was particularly good to see the IDT requesting that specific needs and questions be addressed in assessments.

36. IDTs did not always arrange for and obtain needed, relevant assessments prior to the IDT meeting. Examples for which this did not occur included:

- Individual #140, Individual #15, Individual #61, and Individual #48 all had Structural and Functional Assessments (SFAs) from 2014.
- Individual #147's 30-day ISP was dated 3/8/16. Many assessments were not completed within the required timeframes, including the BHA, vocational, FSA, PSI, and CPE. The SFA was not completed until 8/19/16.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: Progress and implementation were not adequately being reviewed by QIDPs and IDTs. Consequently, actions were not developed or taken. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
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:
Overall, consistent implementation and monitoring of ISP action steps continued to be areas of significant concern. The Center had not had a process in place to consistently monitor the work of the QIDPs and implement corrective action as needed, but had recently initiated some strategies in this area. New staff had been assigned to monitor QIDP responsibilities and to provide mentoring as needed. This was positive and appeared to be resulting in early improvements, but it was too early to assess success and consistency. For example, QIDPs were only beginning in February 2017 to complete their own monthly reviews.

37. Most ISP management has been accomplished through ISPAs instead of through consistent and routine monthly monitoring and review of data, as described above. Still, the ISPA process was not effective in ensuring follow-up on important recommendations and needs. IDTs met frequently to address behavioral and health issues as they arose, but rarely met to address lack of implementation and lack of progress related to ISP action plans. Even for behavioral and health issues, the IDTs often failed to follow-up as needed on the decisions and agreements documented.

38. As described above, it was not possible to confirm the QIDP had been consistently knowledgeable of the goals, preferences, strengths and needs articulated in the individualized ISP, as evidenced by their failure to track implementation of individuals' ISP action plans for many months. The Center had recently reduced the QIDP caseloads to between 10 and 13 individuals per staff member. Some QIDPs still reported feeling that the paperwork workload was excessive and a barrier to carrying out their responsibilities for monitoring and ensuring implementation and modification of the ISP action plans. From the Monitoring Team's perspective, this size caseload should allow QIDPs to easily complete their monthly review and monitoring responsibilities, while also allowing them ample time to spend with the individuals they serve and their staff.

Action plans had not implemented on a timely basis, if at all (as also described elsewhere in this report). QIDPs had not documented monitoring or taking follow-up action as needed for many months. The monthly reviews completed by the contractor, covering multiple months, documented many action plans lacking implementation and requiring follow-up for all individuals. Examples included:

- As of 1/18/16, the QIDP had yet to follow-up on the following action plans for Individual #48's 6/9/16 ISP: his first/then communication SAP, introducing him to animals, taking a trip to the humane shelter, attending group home tours, inquiring with his mother about whether she would visit more often if he moved closer, and the initial assessment for coordination to participate in custodial tasks.
- For Individual #147, many action plans from his 2/16/16 ISP had not implemented as required or at all, including: his PBSP was not completed until November 2016, no action had been taken on joining a Madden gaming, no church outings completed, his OT assessment was not completed until November 2016, and no action had been taken on picking up job applications.

Outcome 1 – Individuals at-risk conditions are properly identified.												
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:									
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	The individual's risk rating is accurate.	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	1/2	0/2	0/2
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	0/2	1/2	0/2	0/2	1/2	0/2	1/2	0/2	2/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #15 – falls, and dental; Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – weight, and dental; Individual #19 – fractures, and weight; Individual #139 – falls, and dental; Individual #46 – constipation/bowel obstruction, and weight; Individual #48 – dental, and cardiac disease; Individual #59 – constipation/bowel obstruction, and behavioral health; and Individual #108 – dental, and falls).

a. The IDTs that effectively used supporting clinical data, and used the risk guidelines when determining a risk level were those for Individual #27 – dental, and Individual #48 - 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. The following individuals did not have changes of status in the identified risk areas: Individual #61 – constipation/bowel obstruction, Individual #139 – falls, Individual #48 – cardiac disease, and Individual #108 – dental, and falls.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	114	140	49	44	81	147	15	61	62

		Score									
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. 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.

The goals need to measurable, have a criterion for success, be presented to the IDT, appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents (as well as be part of the QIDP's monthly review).

In other words, much like the other SSLCs, there were no individualized psychiatric goals for individuals. That is, those that focused upon the individual's psychiatric disorder and monitored progress via what have come to be called psychiatric indicators. Psychiatric providers attended some ISP meetings. This was good to see and sets the occasion for presentation and discussion, as needed, of psychiatric indicators and psychiatry-related personal goals.

Because this facility does not have access to the SSLC electronic health record (IRIS), they will need to obtain and include the psychiatric goals grid being utilized by the other facilities. The Monitoring Team, during discussion while onsite, recommended that the Center contact the state discipline coordinator for psychiatry and perhaps get a copy of the grid that has been used to help guide the creation of psychiatric personal goals that are more likely to meet criteria with this outcome.

In addition to collecting data regarding problematic behaviors, some assessment instruments were being utilized, specifically the DASH II (Diagnostic Assessment for the Severely Handicapped). This scale provided information regarding symptom experience at the time of the administration of the scale. In many cases, there was a comparative review of successive scales included in the psychiatric documents. This was good to see as the comparison of assessment results make these data more useful in monitoring psychiatric symptoms.

Psychiatric progress notes for quarterly clinical encounters routinely documented review of available data. Unfortunately, the data provided for psychiatry were generally stale, in that they were available at best through the end of the month prior. There were

multiple examples of the psychiatrist writing in additional data points and attempting to extend graphs in order to make pharmacological decisions. There were also concerns on the part of both the Monitoring Team and facility staff regarding the validity and integrity of data.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: All individuals had a CPE and this was the case for this review and the last two reviews, too (with one exception in August 2015). Therefore, indicator 12 will be moved to the category of requiring less oversight. Some attention to format and inclusion of all required content categories will likely lead to scores for indicators 13 and 14 meeting criteria. Some attention to documentation may also have the same effect on indicators 15 and 16. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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	56% 5/9	1/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1
14	CPE content is comprehensive.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1
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.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	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.	33% 3/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments:
12-13. CPEs were completed for all individuals. All of the CPE examples were noted to include a large volume of information. For four individuals, Individual #140, Individual #44, Individual #81, and Individual #15, the CPE, despite including a large amount of information, was not in Appendix B format.

14. The Monitoring Team looks for 14 components in the CPE. Seven evaluations were complete and addressed all of the required elements. One evaluation, regarding Individual #15, lacked a sufficient bio-psycho-social formulation. One evaluation, regarding Individual #62, lacked sufficient laboratory data in that the laboratory results were over two years old.

15. For the two individuals admitted since 1/1/14, there were no integrated progress notes from nursing within the first business day following admission. One individual, Individual #147, had a CPE performed within 30 days of admission. The CPE for Individual #49 was not completed within 30 days of admission.

16. There were six individuals whose documentation revealed inconsistent diagnoses: Individual #114, Individual #44, Individual #81, Individual #147, Individual #15, and Individual #62.

Outcome 5 – Individuals' status and treatment are reviewed annually.

Summary: Annual psychiatry updates/evaluations, when done, met all of the criteria in indicator 18. More than half of the individuals, however, did not have psychiatry updates/evaluations completed (though this was an improvement since the last review). The psychiatrist was highly involved with all individuals, but even so, completion of the annual update is an important aspect of the information that IDTs need to consider in creating the overall annual ISP. These five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 114	140	49	44	81	147	15	61	62
17	Status and treatment document was updated within past 12 months.	43% 3/7	1/1	0/1	N/A	1/1	0/1	N/A	1/1	0/1	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	43% 3/7	1/1	0/1	N/A	1/1	0/1	N/A	1/1	0/1	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	1/1	0/1	0/1	0/1	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.	67% 6/9	1/1	1/1	0/1	0/1	0/1	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% 0/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. Seven individuals required annual evaluations. Three were done (Individual #114, Individual #44, Individual #15). Both Individual #81 and Individual #140 had initial evaluations performed within the last year, however, both were admitted to the facility several years prior. Individual #81 was admitted in 2012 and Individual #140 was admitted in 1996, as such, both individuals should have had several re-evaluations. Individual #61 and Individual #62 had not had annual evaluations performed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. The three evaluations completed all met full criteria.

21. There was a need for improvement with regard to the consistent 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. There were examples where some of the required items were included, specifically, there were four examples that included detailed reviews of medication side effects and two examples that included information regarding the rational for determining that the proposed psychiatric treatments represented the least intrusive and most positive interventions. This was good to see. The ISP-IRRF for Individual #114 was not available at the time of this review, so it was scored as N/A.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
Comments: 22. One individual, Individual #81, had a PSP written in December 2015. As such it was out of date and, therefore, did not meet the requirements.											

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: There were signed consent forms for all medications for this review and for the previous two reviews, too (with one exception in August 2015). Therefore, indicator 28 will be moved to the category of requiring less oversight. With sustained high performance, indicators 29 and 32 might move to the category of less oversight after the next review. Extra focus is required for the documentation required by indicators 30 and 31 to meet criteria. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

		0/9									
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
29. The facility was including medication information sheets attached to the consent forms.

30-31. The risk versus benefit discussion was not included in the consent form. Alternate and non-pharmacological interventions were not included. Some examples indicated that there were no alternatives to the medication.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.

Summary: Performance was the same as during the past two reviews, too. That is, individuals had PBSPs, and they had goals that were measurable and that were based upon assessments. Therefore, indicators 1, 2, 3, and 4 will be moved to the category or requiring less oversight. Without reliable data, all of this work can not come to fruition because IDTs, behavioral health services, clinical staff, and facility management can not really know if individuals are progressing or not. Therefore, indicator 5 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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% 11/11	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
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% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
5	Reliable and valid data are available that report/summarize the	0%	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

	individual's status and progress.	0/8									

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 11 required a PBSP (eight of nine individuals reviewed by the behavioral health Monitoring Team and three individuals reviewed by the physical health Monitoring Team). All 11 of those individuals had PBSPs.

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

5. No individuals had interobserver agreement (IOA) or data collection timeliness assessments within 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.											
Summary: These indicators form the foundation for good behavioral treatment and programming. Good performance was hampered by assessments that were not updated. All three indicators were met for some individuals. On the other hand, none of the indicators were met for one individual. Indicators 10 and 11 improved from the last review; indicator 12 received a lower score this time. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
10	The individual has a current, and complete annual behavioral health update.	88% 7/8	1/1	0/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	62% 5/8	1/1	0/1	1/1	1/1	N/A	1/1	0/1	0/1	1/1
12	The functional assessment is complete.	62% 5/8	1/1	0/1	1/1	1/1	N/A	1/1	0/1	0/1	1/1

Comments:
10. Individual #140 did not have an annual behavioral health assessment.

11. Individual #140, Individual #15, and Individual #61 did not have current (written/revised in the last 12 months) functional assessments.

12. All of the functional assessments contained all of the necessary components and were consistently of good quality. Individual #140, Individual #15, and Individual #61's functional assessments, however, were scored as incomplete because they were more than two

years old.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary: Performance remained about the same as during the last review. These indicators require some attention in order for improvement to occur. All three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	25% 2/8	0/1	0/1	0/1	0/1	N/A	0/1	1/1	1/1	0/1
14	The PBSP was current (within the past 12 months).	62% 5/8	1/1	0/1	1/1	1/1	N/A	1/1	0/1	0/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	25% 2/8	1/1	0/1	1/1	0/1	N/A	0/1	0/1	0/1	0/1

Comments:
13. There was documentation that the PBSP was implemented within 14 days of attaining consents for Individual #15 and Individual #61.

14. Individual #140, Individual #15, and Individual #61 did not have current (written/revised in the last 12 months) PBSPs.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Five of the eight PBSPs contained all of those components. Individual #114 and Individual #49's PBSPs were complete. Individual #62, Individual #147, and Individual #44's PBSPs specified the training of the replacement behavior, but did not clearly specify the reinforcement of replacement behaviors. Individual #140, Individual #15, and Individual #61's PBSPs were complete, however, were scored as incomplete because they were more than two years old.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: None of the individuals were referred for, or were receiving counseling services. These indicators will remain in active monitoring for inclusion during the next review.			Individuals:								
#	Indicator	Overall Score									
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A									
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A									

Comments: 24-25. None of the individuals were referred for or had counseling plans. Rio Grande SC had access to the Center's mental health services should individuals be referred by their IDTs.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: During this review, the Center made improvement with regard to the timeliness of annual medical assessments. Indicator c will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	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 (N/R)									
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.											
Summary: Although some additional work was needed, the Center had made progress with regard to the quality of medical assessments. Given that over the last two review periods and during this review, between one and three diagnoses were not justified, Indicator b will remain in active oversight. Indicator c will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual receives quality AMA.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	89% 16/18	2/2	2/2	2/2	2/2	2/2	1/2	2/2	1/2	2/2

c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									

Comments: a. It was positive that Individual #19's annual medical assessment included the necessary components to address her needs. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, 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, as applicable, pre-natal histories, updated active problem lists, and plans of care for each active medical problem. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe family history, and childhood illnesses.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. Clinical justification was present for most of the diagnoses reviewed. However, the exceptions were concerning:

- Individual #46 had a diagnosis of normocytic/normochromic (NC/NC) anemia. The plan to address it included starting folic acid and B12. This is not consistent with the management of NC/NC anemia. Additionally, the individual was treated with fergon with no documentation of iron deficiency.
- Similarly, for Individual #59, there was no evidence to support a diagnosis of anemia requiring iron.

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.											
Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	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 IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

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 #15 – cardiac disease, and gastrointestinal problems (GI) problems; Individual #61 – osteoporosis, and other: hyponatremia; Individual #27 – seizures, and osteoporosis; Individual #19 – seizures, and other: hypothyroidism; Individual #139 – diabetes, and respiratory compromise; Individual #46 – respiratory compromise, and cardiac disease; Individual #48 – diabetes, and other: anemia; Individual #59 – other: anemia, and urinary tract infections (UTIs); and Individual #108 – cardiac disease, and diabetes].

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.											
Summary: The Center needs to focus on the timeliness, as well as the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	N/A									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	11% 1/9	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.										

Comments: a. In its pre-review document request, the Monitoring Team requests the most recent annual dental exam and the previous annual exam. The Center submitted the most recent annual exam and the previous exam (which was usually not the annual exam). Because the Center uses a community dentist, the IPNs were limited to notes the Registered Dental Hygienist (RDH) wrote. The majority of these notes documented dental rehearsals. For future reviews, the Center should submit the two most recent Annual Dental Examinations. Consult notes from the community dentist should be submitted in lieu of the request for dental progress notes/IPNs. The IPNs the RDH writes should also be submitted. The Center should continue the implementation of the Annual Dental Summaries ensuring that the summaries are compliant with the State Office template, which is intended to provide useful information to the IDTs. The document submission oversights have the potential to negatively impact the Center's scores, and should be corrected.

b. On a positive note, all of the dental exams reviewed included, as applicable:

- An odontogram;
- Specific treatment provided; and
- The recall frequency.

Most, but not all of the 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; • Information regarding last x-ray(s) and type of x-ray, including the date; • Periodontal charting; • A description of periodontal condition; • Caries risk; • Periodontal risk; and • A treatment plan. Moving forward, the Center should focus on ensuring dental exams include: • A summary of the number of teeth present/missing. c. All of the dental summaries were missing six or more of the required elements. Moving forward the Center should focus on ensuring dental summaries include the following, as applicable: • Recommendations related to the need for desensitization or other plan; • A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret; • Effectiveness of pre-treatment sedation; • Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health; • Provision of written oral hygiene instructions; • Recommendations for the risk level for the IRRF; • 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.	
Summary: During this review and the last review, improvement was noted with regard to the timeliness of annual nursing reviews and physical assessments. During the next review, if the Center sustains this progress, Indicator a.ii will likely move to the category requiring less oversight. However, regression was noted with regard to the completion of quarterly nursing record reviews and physical assessments. The remaining indicators also require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in	Individuals:

accordance with current standards of practice.											
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	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.	89% 8/9	0/1	1/1	1/1	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.	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	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.	50% 1/2	N/A	N/A	1/1	0/1	N/A	N/A	N/A	N/A	N/A

Comments: b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #15 – falls, and dental; Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – weight, and dental; Individual #19 – fractures, and weight; Individual #139 – falls, and dental; Individual #46 – constipation/bowel obstruction, and weight; Individual #48 – dental, and cardiac disease; Individual #59 – constipation/bowel obstruction, and behavioral health; and Individual #108 – dental, and falls).

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. The following summarize the findings related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- For Individual #27, in an IPN, dated 12/23/16, the nurse described the completion of a very good assessment regarding a fall the individual sustained.
- An IPN, dated 9/6/16, indicated Individual #19's eye was red with green exudate, but the nurse documented no further

assessment of the individual's vision, pain or right eye.

#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Although more work is needed, it was very positive to see some improvement with regard to the inclusion of ongoing nursing assessments and interventions in individuals' IHCPs. The Center is encouraged to continue and expand its efforts to improve the quality of IHCPs. These indicators will remain in active oversight.			Individuals:								
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.	33% 6/18	0/2	2/2	1/2	0/2	0/2	1/2	1/2	1/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	33% 6/18	0/2	2/2	1/2	0/2	0/2	1/2	1/2	1/2	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).	33% 6/18	0/2	2/2	1/2	0/2	0/2	1/2	1/2	1/2	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).	39% 7/18	0/2	2/2	1/2	1/2	0/2	1/2	1/2	1/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	33% 6/18	0/2	2/2	1/2	0/2	0/2	1/2	1/2	1/2	0/2

Comments: a. The IHCPs that sufficiently addressed the individuals' health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice were those for: Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – dental; Individual #46 – constipation/bowel obstruction; Individual #48 – cardiac disease; and Individual #59 – constipation/bowel obstruction.

b. The IHCPs that included preventative measures were those for Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – dental; Individual #46 – constipation/bowel obstruction; Individual #48 – cardiac disease; and Individual #59 – constipation/bowel obstruction.

c. The IHCPs that included 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) were those for Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – dental; Individual #46 – constipation/bowel obstruction; Individual #48 – cardiac disease; and Individual #59 – constipation/bowel obstruction. e. The IHCPs that included the specific clinical indicators to be monitored were those for Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – dental; Individual #19 – weight; Individual #46 – constipation/bowel obstruction; Individual #48 – cardiac disease; and Individual #59 – constipation/bowel obstruction. f. The IHCPs that specified the frequency for monitoring of the individuals' health risks were those for Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – dental; Individual #46 – constipation/bowel obstruction; Individual #48 – cardiac disease; and Individual #59 – constipation/bowel obstruction.

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.											
Summary: It is important that the Center have systems in place for IDTs to make referrals when individuals meet criteria for PNMT referral, and for the PNMT to self-refer should IDTs fail to do so. The quality of the PNMT reviews and comprehensive assessments is also an area on which the Center should focus. This will require the PNMT to involve the disciplines necessary to assess and address the individual's needs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	20% 1/5	1/1	N/A	N/A	0/1	0/1	0/1	N/A	N/A	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	20% 1/5	1/1			0/1	0/1	0/1			0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4	0/1			0/1	N/A	0/1			0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	20% 1/5	1/1			0/1	0/1	0/1			0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/1	0/1			N/A	N/A	N/A			N/A
f.	Individuals receive review/assessment with the collaboration of	0%	0/1			0/1	0/1	0/1			0/1

	disciplines needed to address the identified issue.	0/5									
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% 0/3	N/A			0/1	0/1	N/A			0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4	0/1			0/1	N/A	0/1			0/1

Comments: a. through d., and f. For the five individuals that should have been referred to and/or reviewed by the PNMT:

- On 4/15/16, Individual #15's IDT made a referral to the PNMT in relation to weight loss and skin integrity. Individual #15 had been spending significant amounts of time in bed secondary to a UTI and potentially dementia. The PNMT indicated that they did not receive the referral until 4/18/16. On 4/19/16, the PNMT conducted an initial review, and determined a comprehensive assessment was needed, and it was completed on 5/24/16. No evidence was found to show involvement of Behavioral Health Services staff, Psychiatry Department staff, or a PCP or provider in the assessment process.
- Individual #19 was enterally fed. Between August 2015 and October 2016, she gained 25 pounds, and had a body mass index (BMI) of 50.66. In August 2015, she weighed 177 pounds. In October 2016, she weighed 202 pounds, and she appeared to have stabilized at that weight. However, in July and August 2016, she reached a high of 207 to 209 pounds. There were not significant fluctuations that would suggest changes in fluid retention, though fluid retention was an identified issue and she had swelling in her lower extremities, which were elevated off and on throughout the day in her wheelchair. At various points during this trajectory, her IDT should have referred her to the PNMT, or the PNMT should have made a self-referral of this woman with morbid obesity and numerous other health issues.
- Individual #139's IDT referred him to the PNMT due to weight gain, but the PNMT rejected the referral without a proper review. More specifically, a nursing quarterly review, dated 1/3/17, listed his weight in February 2016 as 135.2 pounds, with gradual increase to 155 in August. This represented a gain of 19.8 pounds, or over a 10 percent increase in six months. His IRRF, dated 9/13/16, indicated that he had presented with a 14.6 percent increase in six months, weighed 12.3 percent more than the year before, and was 10 percent plus over his desired weight range. The IRRF indicated that the PT (also a PNMT member) suggested the IDT make a referral to the PNMT and they did. According to the minutes on 9/27/16, the PNMT received the referral and documented that they looked at his weight and he had only gained 7.2 or 8.2 pounds, and as such did not warrant referral. The discrepancies were not explained.

  There was a notation that the 135.2 weight recorded in February 2016 was questionable, but this was not noted in the RN quarterly assessment. There were a number of missing weights and issues with the procedure used to weigh him, including

which scale they used. The PNMT minutes did not report the February weight, but indicated that his weight in March 2016 was 147.2. It was not clear whether or not he was reweighed after the 135.2 weight obtained in February 2016. If there are discrepancies with weight measurement and documentation, the Center should address these issues to ensure that all team members have access to consistent and reliable weight measurement to address all weight gain and weight loss concerns in a timely manner.

- Individual #46 re-fractured his left ulna, but the IDT did not refer him to the PNMT for this fracture of a long bone, and the PNMT did not self-refer.
- In the six months from May to November 2016, Individual #108 experienced a weight loss of over 10 percent, from 122.6 to 110 pounds, with continued weight loss down to 101 on 1/16/17. On 1/23/17, her IDT finally made a referral. PNMT meeting minutes said she had a qualifying event as of 1/3/17, and with review determined that she had met criteria as far back as her ISP meeting in October 2016.

e. Individual #15 was on the PNMT caseload and was slated for discharge at the time of his hospitalization. The RN Post-Hospitalization Reviews completed for Individual #15 were inconsistent. Two of the four were incomplete. For example, recommendations were not offered in the review document but rather by staff report were discussed at the ISPA, and/or the RN documented the individual refused an assessment, but did not make another attempt to assess him and/or utilize information in the RN Case Manager's assessment. In addition, the PNMT only documented review of two of the four RN Post-Hospitalization Reviews. It was not clearly stated what PNMT actions were indicated in each of the reviews, and the PNMT reviews were not documented in IPNs. Moreover, for the 9/13/16 hospitalization, the PNMT spent most of the review discussing how to document their discussion to the expectations of the Monitoring Team, rather than discussing Individual #15's status and support needs. The PNMT assigned a corrective action plan (CAP) with a due date to complete an IRRF, and an IHCP rather than identify the need to participate in that process themselves.

h. As noted above, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #19, Individual #46, and Individual #108). The following provide some examples of concerns noted in the assessment for Individual #15:

- The assessment did not include any discussion regarding whether or not the risk ratings the IDT assigned required modification based on the PNMT's assessment. The assessment described some of the individual's behaviors, but no evidence was found of collaboration with Behavioral Health Services staff, despite the fact that one of the major factors to his skin issues was the amount of time he was staying in bed, and his refusals to get out of bed. The assessment stated what Individual #15's prescribed caloric and fluid intake totals were, but did not report actual intake at the time of the assessment. The assessment indicated his baseline for walking was 500 feet without rest and 1000 feet with one rest, each with staff assistance. However, the assessment offered no description of amount of assistance he needed. Other documentation described him as requiring staff walking in front of him holding his hands. Recommendations offered were general in some cases, and recommended goals were not clearly related to the etiology or underlying cause of the PNM issues. The physical therapy goal related to getting him up and around, which was good to see, but the assessment identified baseline as 500 feet/1000 feet, and so it was unclear why the goal was only 200 feet four times per week.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.	
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM	Individuals:

needs.											
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	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.	0% 0/18	0/2	0/2	0/2	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.	28% 5/18	1/2	0/2	1/2	0/2	1/2	0/2	2/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: weight, and skin integrity for Individual #15; GI problems, and falls for Individual #61; choking, and falls for Individual #27; aspiration, and weight for Individual #19; weight, and choking for Individual #139; aspiration, and falls for Individual #46; choking, and aspiration for Individual #48; choking, and falls for Individual #59; and falls, and weight for Individual #108.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was the IHCP for choking for Individual #48.

b. The IHCPs that included preventative physical and nutritional management interventions to minimize the individuals' risks were for choking for Individual #48, and choking for Individual #59.

c. All individuals reviewed had PNMPs and/or Dining Plans. Concerns were noted with between three and nine elements within each of the PNMPs and/or Dining Plans reviewed. The Center is encouraged to review the audit tool for this indicator, and take steps to improve compliance with the expected elements of PNMPs.

g. The IHCPs reviewed that include the frequency of monitoring/review were those for weight for Individual #15; choking for Individual #27; choking for Individual #139; and choking, and aspiration for Individual #48.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Since the last review, the Center showed improvement with Indicator a.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	100% 1/1	N/A	N/A	N/A	1/1	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.	N/A				N/A					
Comments: a. Individual #19's IDT provided clinical justification for continued total enteral nutrition.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center should focus on the timeliness as well as the quality of OT/PT assessments and updates. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	N/A	N/A	N/A	N/A	N/A	N/A	N/R	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.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an	13% 1/8	0/1	0/1	0/1	0/1	0/1		0/1	0/1	1/1

	assessment is completed in accordance with the individual's needs.										
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	63% 5/8	0/1	1/1	0/1	1/1	1/1		1/1	0/1	1/1
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	N/A	0/1	N/A	N/A		N/A	0/1	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	N/A	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% 0/6	0/1	0/1	0/1	0/1	N/A		N/A	0/1	0/1

Comments: Individual #46 had functional motor and self-help skills. He was part of the outcome group, so a limited review was conducted.

a. and b. One of the seven individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. The following concerns were noted:

- Individual #15's OT/PT update, dated 2/29/16, included no OT content.
- Individual #61's OT/PT update was originally submitted on 5/20/16 with just the PT component, but the OT content was added on 5/26/16. Her ISP meeting was on 5/31/16.
- On 10/4/16, Individual #27's screening was completed for her annual ISP meeting, which was held on 10/18/16. The PCP made a referral, and on 10/31/16, the therapist updated the screening. However, on 10/19/16, treatment was initiated, nearly two weeks earlier than the assessment.
- The documentation for Individual #19 was confusing. An update, dated 5/14/16, was completed for her ISP meeting, which

was held on 5/24/16. Without explanation, the PT submitted an update, dated 5/26/16, two days after the ISP meeting.

- On 9/13/16, Individual #139's ISP meeting was held, but the comprehensive evaluation was not completed until 9/31/16. The evaluation indicated that the IDT requested a consult, and that the annual assessment fulfilled the team's request. The Center submitted no ISPA meeting documentation or other evidence to explain why the IDT requested an OT consult, or why the annual assessment was late.
- On 5/27/16 and 5/31/16, Individual #48 had two different comprehensive assessments completed for an ISP meeting held on 6/9/16. It was unclear why two assessments were completed.
- On 9/19/16, an OT/PT screening was completed for Individual #59, for an ISP meeting on 10/6/16. However, Individual #59 needed an annual update, because he had a PNMP.

In its comments on the draft report, the State indicated: "It is important to note that there was not a full time, nor contract OT working at the facility during that time." The Monitoring Team agrees that this is extremely concerning. Given the requirements of the Settlement Agreement as well as the ICF/ID requirements, the Center should have a back-up system in place to ensure that when a therapy vacancy occurs, individuals still have access to needed therapy services and supports.

c. Individual #59's screening should have identified that he needed an update, because of the use of the PNMP, but it did not.

Similarly, Individual #27's screening should have identified the need for an update. She had a PNMP, and her falls were not all seizure-related. In addition, in the ISP meeting, the PT stated that she required assistance on uneven surfaces and in unfamiliar environments. The RN Case Manager stated that Individual #27 had falls/seizures in the shower, and asked for a shower chair as well as a helmet. The OT/PT had not identified these needs.

d. The Monitoring Team reviewed comprehensive OT/PT assessments for two individuals. The following summarizes some of the problems noted:

- The individual's preferences and strengths were used in the development of OT/PT supports and services: The assessments merely listed strengths and preferences, but did not apply them to the provision of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Individual #139's assessment indicated he had fewer falls, but provided no data to support this finding; and Individual #48's assessment did not sufficiently address his mealtime supports, given his risk for choking/aspiration;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: The assessors did not discuss whether or not medications were potentially impacting individuals' OT/PT problems;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living: Individual #48's assessment provided a limited functional description of his motor skills and abilities, particularly fine motor, and rather described them as "fair";
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): This indicator was not applicable to Individual #48. Individual #139's assessment provided no reference to possible gait belt use. Based on a note from nursing, dated 8/24/16, staff tried to hold him up the best they could, but he fell. Nursing staff described him as tall and hard to support;

- 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: The assessors did not offer data and/or complete descriptions of individuals' current functioning and how that may or may not have been consistent with functional motor performance documented in previous assessments;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: No monitoring findings were reported for Individual #48. For Individual #139, the assessment stated monthly monitoring had occurred, but only referenced monitoring on 9/1/16;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: Individual #139's assessment did not provide discussion regarding the potential use of a gait belt to address fall risk or the use of hand rails due to his visual impairment; and Individual #48's assessment provided such insufficient detail it was difficult to determine whether or not he required OT/PT supports; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address Individual #139's needs were not. Individual #48's assessment recommended reassessment as needed or in two years, but he used a PNMP and so an annual update was required.

On a positive note, all of the comprehensive OT/PT assessments the Monitoring Team reviewed included, as applicable:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs.

e. As noted above, Individual #27 and Individual #59 should have had updates, but did not. Unfortunately, significant issues were noted with regard to the quality of the OT/PT updates for the remaining individuals. The following summaries some examples of concerns noted with regard to the required components of OT/PT assessments:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: Often, updates did not discuss whether or not changes in the individual's health status had an impact on his/her OT/PT needs. The only exception to this was Individual #19's update;
- The individual's preferences and strengths are used in the development of OT/PT supports and services: The majority of updates reviewed merely listed the individuals' strengths and preferences, but did not use them in the development of supports or recommendations. The only exception to this was for Individual #108;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Individual #61's update merely stated that she was at medium risk for falls and fractures. It indicated that she "cannot" use a walker as she previously used it as a weapon, but did not address whether she should be using one and that strategies to address her behavior were indicated;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For a number of individuals, the updates provided limited discussion of the impact of medications on the individual and his/her OT/PT supports (e.g., Individual #19, Individual #15, Individual #59, and Individual #108), and/or provided contradictory information (e.g., Individual #61);
- 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: Descriptions provided were not thorough (e.g., "fair," or deficits noted without any details) and/or did not offer functional examples of the individual's skills;
- 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): The only update that met this criterion was for Individual #15. It was not applicable to Individual #108. Individual #19's update indicated a new wheelchair needed to be ordered within the next six months, but did not sufficiently address her poor posture in the current wheelchair;

- 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: The only update that met this criterion was for Individual #108. Others did not reference the individual's past status, or provided no analysis of the information. For example, Individual #61's IRRF indicated that she had 12 falls, including four due to behavior, seven while walking, and one because she was in a chair that tipped over. The PT did not report this pattern of falls or attempt to investigate, but rather indicated her falls were due to behavior only;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including monitoring findings: Often times, data was missing from the assessments (e.g., numbers of falls), and/or monitoring results were not discussed;
- 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: Because individuals did not have goals/objectives that were clinically relevant and measurable, the updates did not include evidence regarding progress, maintenance, or regression. In other instance due to lack of data and analysis (as discussed above), it remained unclear whether or not current supports were working, and/or if the individual would benefit from different or new 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 throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members: None of the updates reviewed included recommendations to address strategies, interventions, and programs necessary to meet individuals' needs.

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.

Summary: Over the last two reviews and this one, the Center's scores for these indicators varied. It was good to see some improvement from the last review with regard to IDTs reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually. The Monitoring Team will continue to review these indicators.

Individuals:

#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	25% 2/8	0/1	0/1	1/1	0/1	0/1	N/R	0/1	0/1	1/1
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.	63% 5/8	0/1	0/1	1/1	1/1	1/1		0/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy	0%	0/1	0/1	N/A	0/1	0/1		N/A	N/A	N/A

	interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0/4									
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% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: b. For some individuals, ISPs did not include documentation of the IDT's discussion of their PNMPs. This was particularly concerning for Individual #15 and Individual #61, who continued to have falls.

c. and d. Examples of concerns noted included:

- Individual #15's assessment did not recommend direct therapy, but recommended that staff implement a walking program. This was not included in his ISP.
- The PT recommended that Individual #19 continue to complete lower extremity exercises, as well as raising and lowering her leg rests. These staff service objectives were not included in her ISP.
- The OT/PT assessment recommended that Individual #139 walk with the assistance of staff, and with a peer. The IDT did not carry these recommendations over to the ISP, and provided no rationale for not including them.
- For Individual #27, the IDT held an ISP meeting on 10/18/16, but did not discuss the need for direct PT. The screening for the ISP had an attachment, dated 10/31/16, responding to a physician referral for PT, but this was weeks after the first PT treatment according to IPNs, and there was no evidence the IDT held an ISPA meeting to add this service.

Communication

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

Summary: During this review and the past one, the communication updates showed some good improvement in quality, but more work was needed to ensure updates thoroughly addressed all of the necessary components. Timeliness also was improving, but needed continued focus. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 15	61	27	19	139	46	48	59	108
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.	N/A	N/A	N/A	N/R	N/A	N/A	N/R	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.	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.	57% 4/7	1/1	1/1		0/1	0/1		0/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 7/7	1/1	1/1		1/1	1/1		1/1	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.	33% 1/3	0/1	0/1		N/A	N/A		N/A	1/1	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	0/1		N/A	N/A		N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	50% 2/4	N/A	N/A		1/1	0/1		0/1	N/A	1/1

Comments: Individual #27, and Individual #46 had functional communication skills. They were part of the outcome group, so they were not included in the review of these indicators.

c. Individual #15 and Individual #61's screenings did not identify when they would require reassessment. In addition, Individual #61's screening did not provide justification for yes and no answers, and contained a number of discrepancies. For example, it stated that further assessment was indicated, yet also stated that no assessment was needed. It indicated that a Communication Dictionary (CD) and strategies were needed, yet also stated these were not indicated.

On a positive note, the SLP had self-identified the issues with the screenings, and subsequent ones were much improved with clear rationale provided for yes/no answers.

d. Individual #61's screening indicated that according to the previous assessment, an assessment of her communication skills was needed in January 2017, yet one was not provided for the current ISP.

e. It was positive that Individual #108's communication update included all of the necessary components to identify her needs, and incorporate her strengths and preferences. The following summaries some examples of concerns noted with regard to the required components of the remaining communication assessments:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: For Individual #48, the update did not discuss the individual's health status over the last year, but merely listed diagnoses;
- 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: Individual #139's update described his communicative behavior in good detail, but did not discuss the potential for sensory activities to address resistive behavior, and to expand his basic communication skills, nor did the SLP refer the individual to the OT to address these concerns;
- The effectiveness of current supports, including monitoring findings: Individual #139's update indicated that monitoring did not occur due to the restructuring of the Vocational Education program. However, the update did not explain whether or not the SAP that Vocational staff were supposed to implement was revised and/or implemented in another setting in the interim;
- 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 services: For Individual #139, the assessor did not explore sensory activities in collaboration with the OT or Behavioral Health Services staff; 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: As noted above, Individual #139's update lacked recommendations to build on existing communication skills.

On a positive note, all of the communication updates reviewed included:

- The individual's preferences and strengths are used in the development of communication supports and services; and
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

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.	
Summary: Since the last review, the Center's scores for these indicators had essentially remained the same. These indicators will continue under active monitoring.	Individuals:

#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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/R	0/1	0/1	N/R	0/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/5	N/A	0/1		0/1	0/1		0/1	N/A	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.	67% 2/3	N/A	0/1		1/1	N/A		1/1	N/A	N/A
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. For a number of the individuals reviewed, the communication descriptions in their ISPs were missing key components, such as how the individual used AAC devices in relevant settings, how the individual communicated with others, the individual's primary language, etc. For example:

- For Individual #15, a screening completed after the ISP meeting provided a good description of his communication skills, but unfortunately, this information was not available to the IDT at the time of the ISP meeting. As a result, the information in his ISP was incomplete.
- Individual #139's ISP primarily addressed how he would be addressed during the ISP meeting, rather than also describing his functional communication skills throughout his day.

b. Although individuals' ISPs often referred to their Communication Dictionaries, it was unclear whether or not IDTs had reviewed them, and revised them, as appropriate.

c. It was positive that for two individuals reviewed, IDTs incorporated the strategies, interventions, and programs the Speech Language Pathologist recommended in the assessment into the individuals' ISPs. The exception was the IDT of Individual #61.

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.	
Summary: Each individual had SAPs, though three individuals had less than three	Individuals:

SAPS, which was surprising given their many skill needs. Most SAPs were written in measurable terms, which was good to see, but many were not based on assessment results and/or were not practical, functional, or meaningful for the individual. For all SAPs, there was no confidence in the recorded data being reliable. All five indicators will remain in active monitoring.											
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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.	87% 20/23	1/2	2/3	3/3	3/3	2/3	1/1	2/2	3/3	3/3
3	The individual's SAPs were based on assessment results.	70% 16/23	2/2	1/3	2/3	1/3	2/3	1/1	2/2	2/3	3/3
4	SAPs are practical, functional, and meaningful.	48% 11/23	1/2	0/3	1/3	1/3	2/3	0/1	2/2	1/3	3/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/23	0/2	0/3	0/3	0/3	0/3	0/1	0/2	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 #15 and Individual #114, and one SAP for Individual #147, for a total of 23 for this review.

2. The objectives for Individual #81 and Individual #140''s use a knife to cut food SAPs and Individual #114's wash clothes SAP were not clearly defined.

3. Seventy 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 #81's using a knife to cut food SAP).

4. Forty-eight percent of the SAPs were practical and functional (e.g., Individual #49's use the clothes dryer SAP). The SAPs that were judged not to be practical or functional either represented a compliance issue rather than a new skill (i.e., Individual #61's point to her medication SAP), or were skills that assessments had indicated the individual already possessed (i.e., Individual #140''s brush her teeth 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.												
Summary: Performance increased for indicators 10 and 11 compared with the last review, and remained the same for indicator 12. With sustained high performance, indicator 10 might move to the category of requiring less oversight after the next review; the other two indicators will require some attention. Improvement in indicators 11 and 12 may have a beneficial impact on indicators 1, 2, 3, and 4 because recommendations from these assessments may set the occasion for the IDT to develop more SAPs that are relevant for the individual's life. The three indicators of this outcome will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	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.	44% 4/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 11. Individual #147 and Individual #61's vocational assessments were not available to the IDT at least 10 days prior to their ISPs. Additionally, Individual #140 and Individual #44's PSIs, and Individual #49's FSA were not available to the IDT at least 10 days prior to their ISPs. 12. Only Individual #114's FSAs and vocational assessments included recommendations for skill acquisition plans.												

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.

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Nine of these, in psychiatry, psychology/behavioral health, medical, and pharmacy sustained high performance scores and will be moved the category of requiring less oversight. This included one full outcome in psychiatry (outcome 12).

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Goals/Objectives and Review of Progress
Regarding management of frequent restraints (i.e., more than three in any rolling 30-day period), this was the first time that Rio Grande SC had any individuals who had this many restraints. Overall, IDTs met, but did not accomplish what is required during the review. This outcome and its indicators will require attention (in the same way as described in Domain 1 above).

Reiss screens have not been routinely conducted at Rio Grande SC, but need to be for those who do not already receive psychiatry services.

In psychiatry, without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. The review and management of polypharmacy met the criteria required for these indicators for a number of years. Psychiatry was very involved with behavioral health services as evidenced in the positive scoring for these two indicators for all individuals (except for those whose behavioral health assessments and/or PBSPs were out of date). Psychiatry clinics (called QMRs at Rio Grande SC) were conducted thoroughly and at criteria. Unfortunately, recent target behavior data were not available at these reviews.

In behavioral health, given the absence of good, reliable data, progress could not be determined for all of the individuals (same as at the last review). Progress notes, adequate data collection systems, graphs, up to date data, and peer review are aspects of behavioral health service that should be occurring regularly, but weren't.

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. 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.

Acute Illnesses/Occurrences
Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. For the acute care needs reviewed, nursing staff had developed acute care plans, which was positive. It was also good that one met criteria. However, substantially more work is needed to ensure all acute care plans meet individuals' needs, and that they are implemented.

Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. On a positive note, over the last two review periods and during this review, when individuals were transferred to the hospital, a practitioner or a nurse generally communicated necessary clinical information with hospital staff. As a result, the related indicator will move to the category requiring less oversight.

The availability, provision, and documentation of emergency/urgent and/or follow/up interim psychiatry clinics met the criteria required for these indicators for a number of years and these indicators moved to the category of requiring less oversight.

Implementation of Plans
Although IHCPs now sometimes defined the regular nursing assessments individuals needed, documentation was not found to show ongoing implementation of such assessments.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. However, for the limited action steps assigned to PCPs in IHCPs, documentation often was found to show implementation.

The Center should focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

Since the last review, improvement was noted in terms of PCPs reviewing consultations and indicating agreement or disagreement, doing so in a timely manner, and writing IPNs that included the necessary components. The Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and that IDTs review the recommendations and document their decisions and plans in ISPAs.

Significant improvement was noted with regard to medical practitioners reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable (i.e., during the last review, the Center's score was 0%, and during this review, it increased to 78%). This was good to see.

Problems were noted for the individuals' reviewed with regard to dental care and treatment. Overall, there appeared to be problems with the provision of adequate daily oral care. The records frequently documented that individuals presented to the clinic for dental rehearsals with food impactions and evidence of a lack of proper home oral care. The Center should focus on improving individuals' daily oral care. In addition, it was also not clear how the behavioral health services staff were assisting in addressing barriers to the provision of dental services.

The Center also should focus on ensuring individuals receive timely prophylactic dental care, fluoride treatment as appropriate, treatment for periodontal disease, and restorations. Improvements also are needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. On a positive note, during dental rehearsals, Dental Department staff provided tooth-brushing instruction to the individuals reviewed and/or their staff, and individuals generally received needed dental x-rays.

The Center should focus on the timely completion and quality of QDRRs. The Center did well with the practitioner review of the QDRRs during this review and the last two, so the related indicator will move to the category of less oversight. The Center also should maintain its performance with regard to the implementation of the agreed-upon recommendations.

Adaptive equipment was generally clean and in good working order. However, proper fit was still an issue.

Based on observations, although the Center had made some progress, there were still many instances (47% of 45 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

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.	
Summary: This was the first review during which any individuals had restraints such that these indicators applied. With additional attention, it is likely that these indicators can all obtain high scores with some possibly moving to the category of	Individuals:

less oversight after the next review. They will remain in active monitoring.											
#	Indicator	Overall Score	49	44	61						
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.	100% 3/3	1/1	1/1	1/1						
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.	100% 3/3	1/1	1/1	1/1						
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.	33% 1/3	0/1	0/1	1/1						
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.	33% 1/3	1/1	0/1	0/1						
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?	67% 2/3	1/1	1/1	0/1						
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 them.	67% 2/3	0/1	1/1	1/1						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	67% 2/3	1/1	1/1	0/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	0% 0/3	0/1	0/1	0/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	N/A	N/A	N/A	N/A						
28	The individual who was placed in crisis intervention restraint more	0%	0/1	0/1	0/1						

	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.	0/3									
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.	67% 2/3	1/1	1/1	0/1						

Comments:
This outcome and its indicators applied to Individual #49, Individual #44, and Individual #61.

18-19. For all three individuals, the IDT met to review restraints following one or two restraints. It would appear to be more efficient, however, if the team met less frequently, but did a complete review every few months, or when something new occurred, rather than repeating the same things several times a month.

20. Individual #61's IDT hypothesized that psychiatric instability contributed to the occurrence of her dangerous target behaviors that provoked restraint. Additionally, the IDT suggested scheduling a psychiatric clinic to address her psychiatric issues. Both Individual #49's and Individual #44's ISPAs suggested several medical and psychosocial issues, that potentially have contributed to their restraints, however, no actions were presented to address those issues.

21. Individual #49's ISPA indicated that more restraints occurred in the afternoon, and the IDT suggested that more preferred activities would be provided in the afternoon to address this potential setting event. Contributing environmental variables were not discussed in Individual #44's or Individual #61's IDT.

22. Individual #49 and Individual #44's ISPAs identified several antecedents that potentially contributed to their restraints, and actions to address those hypothesized antecedents to dangerous behaviors that provoked restraint. Individual #61's ISPA indicated that the removal of items (e.g., wheelchair, radio) resulted in aggression that provoked restraint. No action, however, to address this antecedent to restraint was discussed.

23. Individual #44 and Individual #61's ISPAs identified maintaining variables that the IDT believed contributed to their restraints, and actions to address these hypothesized maintaining variables. Individual #49's ISPA did not address variables potentially contributing to his restraints.

24. Individual #61's PBSP was dated 9/30/14.

25. None of the individuals had a Crisis Intervention Plan.

28. None of the individuals had treatment integrity data.

29. There was no evidence that the IDT reviewed Individual #61's PBSP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Reiss screens have not been routinely conducted at Rio Grande SC as evidenced by 0% scores at this review and at the previous two reviews, too. This outcome and its indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	108	19							
1	If not receiving psychiatric services, a Reiss was conducted.	0% 0/2	0/1	0/1							
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							
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							
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, two individuals were not receiving psychiatric services. Both, Individual #19 and Individual #108, were not 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.											
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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 their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented. This was evident for all individuals.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: Psychiatry was very involved with behavioral health services as evidenced in the positive scoring for these two indicators for all individuals, except those who behavioral health assessments and plans were out of date (by more than two years in some cases). Thus, these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
23	Psychiatric documentation references the behavioral health target behaviors, <u>and</u> the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	63% 5/8	1/1	0/1	1/1	1/1	N/A	1/1	0/1	0/1	1/1
Comments: 23. The psychiatric documentation referenced specific behaviors that were being tracked by behavioral health, for example, physical aggression, verbal aggression, and self-injury. The psychiatrist attempted to correlate the behavioral health target behaviors to the diagnosis. In addition, the functional assessment included information regarding the individual's psychiatric diagnosis and included the effects of said diagnosis on the target behaviors. This was all very good to see. Because three individuals did not have current functional assessments (Individual #61, Individual #15, Individual #140), they were not scored as meeting criterion for this indicator. 24. There was documentation of the psychiatrist's review of the PBSP in the psychiatric clinical documentation. In addition, in the psychiatry clinical encounters observed during the monitoring visit, the psychiatrist asked questions and made comments regarding the PBSP. Similar to the above indicator, Individual #61, Individual #15, and Individual #140 not have current PBSPs and, therefore, were not scored as meeting criterion for this indicator.											

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.											
Summary: All three indicators did not meet criteria and all three scored lower than during the last review. With additional focus, it is likely that these indicators can show improved performance. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62

25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/4	N/A	0/1	N/A	N/A	N/A	0/1	0/1	0/1	N/A
26	Frequency was at least annual.	25% 1/4	N/A	0/1	N/A	N/A	N/A	0/1	0/1	1/1	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	50% 2/4	N/A	1/1	N/A	N/A	N/A	0/1	0/1	1/1	N/A

Comments:

25 and 27. These indicators applied to four individuals. In one case, Individual #147, it was noted that he was referred to neurology, but did not attend the consultation. Subsequently, facility medical staff discontinued this individual's seizure medication in the absence of neurology collaboration. Neurology consultation reportedly occurred off campus, making collaboration a challenge. Neurology consultations provided for review were detailed. In the records of two individuals, Individual #61 and Individual #140, there was documentation from both neurology and psychiatry regarding the treatment plan.

26. This indicator applied to four individuals. One individual's documentation, Individual #61, met the annual criterion.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
33	Quarterly reviews were completed quarterly.	78% 7/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	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% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments:

33. There were delays in the completion of quarterly evaluations for Individual #44 and Individual #81.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing one to four components; most commonly, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, appropriate data, and basic information (timely height, weight, and vital signs).

35. Psychiatry clinic (called the QMR at Rio Grande SC) was observed for Individual #62. Six of the seven sub-indicators evaluated by the Monitoring Team occurred and met criterion. During the clinic, the psychiatrist asked all the right questions and reviewed the information. He taught and instructed the team as he conducted and led clinic. However, the seventh, regarding data used by psychiatry staff, did not meet acceptable standards in a variety of ways. This affected the psychiatrist's ability to make data based decisions resulting in having to rely on bad data or anecdotal information. Data were only provided through the previous month, that

is, weeks prior to the clinic. Data were not being collected on the specific psychiatric indicators for each psychiatric disorder (i.e., psychiatry indicators 4-7).

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: The Monitoring Team looks at four aspects of review conduct and prescriber review. For the most part (all but once), the review was conducted, however, for six of the individuals, the prescriber review was done, but not done timely. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	33% 3/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
Comments: 36. Assessments and prescriber review of assessments were not routinely occurring in a timely manner.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: The availability, provision, and documentation of emergency/urgent and/or follow/up interim clinics met the criteria required for these indicators for a number of years. These three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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: 37-38. Emergency/interim clinics were available to all individuals and there was documentation of emergency/interim clinics occurring for all nine individuals. It was noted that there were multiple additional clinical encounters for all of these individuals. These regularly occurring follow-up visits were a strength for this facility. At Rio Grande SC, interim clinics were called psychiatry clinic and the regularly scheduled quarterly clinics were called quarterly medication reviews (QMR). 39. When clinics occurred, documentation was appropriate.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: Indicators 40 and 41 met criteria during this review and the previous two reviews, too. They will, however, remain in active monitoring and may be considered for less oversight after the next review. Absence of a current treatment plan resulted in three individuals not meeting criteria for indicator 42, which will also remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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.	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	0/1	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: 42. There were three individuals, Individual #140, Individual #15, and Individual #61, who did not have a current PBSP, and as such, were receiving what could be considered medication in the absence of treatment program. 43. The facility did not utilize 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.											
Summary: The review and management of polypharmacy met the criteria required for these indicators for a number of years. Therefore, indicators 44 and 45 will be moved to the category of requiring less oversight. With sustained high performance, indicator 46 might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 5/5	1/1	N/A	1/1	N/A	N/A	N/A	1/1	1/1	1/1
45	There is a tapering plan, or rationale for why not.	100% 5/5	1/1	N/A	1/1	N/A	N/A	N/A	1/1	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.	80% 4/5	1/1	N/A	1/1	N/A	N/A	N/A	1/1	0/1	1/1

Comments:
44. These indicators applied to five individuals. Polypharmacy justification was appropriately documented for all individuals.

45. There was documentation for all five individuals showing a plan to taper various psychotropic medications.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for four individuals selected by the Monitoring Team meeting criteria for polypharmacy. One individual, Individual #61, met criteria for polypharmacy as of November 2016. She had not been added to the polypharmacy tracking list as of this monitoring visit.

The polypharmacy committee meeting was observed during the visit and was a thorough facility level review of regimens. This was very good to see and was also the case during the last two reviews, too.

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.

Summary: Given the absence of good, reliable data, progress could not be determined for all of the individuals (same as at the last review). The Monitoring Team scored indicators 7, 8, and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 114	140	49	44	81	147	15	61	62
6	The individual is making expected progress	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	0% 0/5	0/1	N/A	N/A	0/1	N/A	N/A	0/1	0/1	0/1
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 #114, Individual #44, Individual #15, Individual #61, and Individual #62 were not making progress on PBSP target behavior objectives, according to their progress notes. Individual #49, Individual #147, and Individual #140's progress notes indicated that they were making progress on one or more target behaviors in the PBSP, however, the data were not demonstrated to be reliable

(see indicator #5), so these individuals were not scored as progressing (see indicator 26 below).

7. Individual #49's aggression, disruption, and SIB objectives were achieved in October 2016, but continued into November, 2016. Individual #147 achieved his target behavior objectives in November 2016, however, the November 2016 progress note did not indicate that objectives would be changed.

8. Individual #44, Individual #114, Individual #15, Individual #61, and Individual #62 were not making expected progress, however, their progress notes did not include actions to address the absence of progress. Intervening when progress is not occurring is a typical aspect of behavioral health services programming and should be occurring regularly at Rio Grande SC.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.

Summary: More training needs to occur for all staff members regarding individuals' PBSPs, thus, indicator 16 will remain in active monitoring. PBSP summaries existed for all individuals and PBSPs were written by BCBAs at Rio Grande SC. This has been the case for the past two reviews, too. Therefore, indicators 17 and 18 will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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.	25% 2/8	0/1	0/1	0/1	1/1	N/A	1/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1

Comments:

16. Only Individual #44 and Individual #147 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) working in their residence were trained on their PBSPs.

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.

Summary: Progress notes, graphs, up to date data, and peer review are aspects of behavioral health service that should be occurring regularly. With some focused attention, higher performance should be attainable for Rio Grande SC on all five of

Individuals:

these indicators. They will remain in active monitoring.											
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
19	The individual's progress note comments on the progress of the individual.	75% 6/8	1/1	1/1	0/1	1/1	N/A	0/1	1/1	1/1	1/1
20	The graphs are useful for making data based treatment decisions.	50% 4/8	0/1	0/1	0/1	1/1	N/A	1/1	1/1	1/1	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
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 eight individuals had timely progress notes that described the individual's progress. Individual #49 and Individual #147's progress notes, however, did not accurately describe their progress.

20. All progress notes had graphs. Individual #61, Individual #15, Individual #147, and Individual #44's graphs encouraged data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. The ability of the graphs to encourage 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. In order to score this indicator, the Monitoring Team observed Individual #62's psychiatric clinic meeting. Data were available up to 2/12/17, however, due to recent medical issues, Individual #62's psychiatrist wanted to determine if recent medical issues affected his target behaviors. The most recent target behavior data were not available to assist the IDT to make a data based decision concerning the role of medical issues on Individual #62's target behaviors.

22. Rio Grande SC did not conduct peer review (see indicator #23).

23. In the last six months, Rio Grande SC's two BCBAs (and often a behavioral consultant) routinely met to review individuals' functional assessments and PBSPs. These meetings, however, 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.											
Summary: Performance scores were the same as during the last two reviews and, given the overall needs for data collection improvement, all five will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 8/8	1/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
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% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

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, which requires the DSP to record antecedents and consequences for each target behavior, is typically 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. For example, the Monitoring Team observed an aggression (no injury occurred) by Individual #140 towards Individual #46 on 3/2/17 in the mid-morning. A recording of this occurrence (i.e., via what Rio Grande SC called a behavior referral slip) did not occur.

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 utilized an interval scoring method and represented an adequate tool for measuring replacement behaviors.

28. There were established measures of IOA and treatment integrity. There were no established measures of data collection timeliness.

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. None of the 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.

Summary: For individuals reviewed, IDTs generally did not have a way to measure outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 15	61	27	19	139	46	48	59	108
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	0/2	1/2	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.	6% 1/18	0/2	0/2	1/2	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 #15 – cardiac disease, and GI problems; Individual #61 – osteoporosis, and other: hyponatremia; Individual #27 – seizures, and osteoporosis; Individual #19 – seizures, and other: hypothyroidism; Individual #139 – diabetes, and respiratory compromise; Individual #46 – respiratory compromise, and cardiac disease; Individual #48 – diabetes, and other: anemia; Individual #59 – other: anemia, and UTIs; and Individual #108 – cardiac disease, and diabetes).

From a medical perspective, the goal/objective that was clinically relevant, achievable, and measurable was for: Individual #27 – seizures. 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.											
Summary: Four of the nine individuals reviewed received the preventative care they needed. During this review and the last two reviews, the overall percentages have varied. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until improvement is achieved, and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. Significant improvement was noted with regard to medical practitioners reviewing and addressing, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable (i.e., during the last review, the Center's score was 0%). This was good to see.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	75% 3/4	N/A	1/1	1/1	0/1	N/A	N/A	N/A	N/A	1/1
	iii. Breast cancer screening	25% 1/4	N/A	1/1	0/1	0/1	N/A	N/A	N/A	N/A	0/1
	iv. Vision screen	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	75% 6/8	0/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1	0/1

	vii. Cervical cancer screening	33% 1/3	N/A	1/1	N/A	0/1	N/A	N/A	N/A	N/A	0/1
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.	78% 7/9	1/1	0/1	1/1	1/1	N/A	1/1	0/1	1/1	1/1

Comments: a. The following provide examples of problems noted:

- Individual #15 refused a DEXA scan, and it was unclear what, if any, steps staff were taking to assist him to complete the test.
- The Center did not provide a mammogram report to confirm that one was done for Individual #27.
- In 2011, a computed tomography (CT) of Individual #19's pelvis showed a mass. In 2013, it was not seen on the pelvic ultrasound. In 2015, the gynecologist recommended annual pelvic ultrasounds in lieu of Pap smears and bimanual exams. The PCP agreed, but documentation was not submitted of a completed ultrasound.
- On 9/30/15, Individual #139 had an eye evaluation with a recommendation to return in one year, for which documentation was not found.
- For Individual #108:
  - On 6/4/14, the gynecologist documented the inability to complete a pelvic exam, and recommended that Individual #108 return in one year. No documentation was found of a return appointment.
  - In addition, her last mammogram was completed in 2012. In 2014, she was uncooperative, but there was no plan to address this issue.
  - On 11/30/11, a DEXA scan showed osteopenia of the lumbar spine and normal bone mineral density of the hip. The PCP documented that Prolia was not indicated, and the IRRF indicated that calcium, Vitamin D, and a follow-up bone scan were the supports needed. However, no follow-up DEXA was submitted.

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. It was positive to see that PCPs had done this for seven of the nine individuals. The following provides an example of problems noted:

- Individual #48's PCP discussed his risk factors in the AMA. However, the important risk for diabetes mellitus/metabolic syndrome was rated as low, which appeared to be inaccurate. Additionally, the QDRR cited prolactin as a monitoring parameter for the use of risperidone, but the PCP did not discuss this in the AMA, and no level was documented.

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.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual with DNR Order that the Facility will execute has clinical	N/A									

	condition that justifies the order and is consistent with the State Office Guidelines.										
Comments: Based on documentation the Center provided, none of the individuals in the ICF component of Rio Grande State Center had DNR Orders in place.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, a provider or a nurse communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 100% for Indicator 4.f, and Round 11 - 100% for Indicator 6.f), Indicator f will move to the category requiring less oversight. However, overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	18% 2/11	0/1	0/2	N/A	0/1	0/1	1/2	0/2	1/2	N/A
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.	27% 3/11	0/1	1/2		0/1	0/1	0/2	1/2	1/2	
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, or 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.	25% 1/4	0/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	0/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 1/2	1/2					N/A			N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring	75% 3/4	2/2					1/1			0/1

	out-of-home care.										
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 4/4	2/2					1/1			1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	50% 2/4	1/2					1/1			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	0/2					1/1			0/1

Comments: a. and b. For seven of the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 11 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #15 (abdominal distention on 9/12/16), Individual #61 (self-injurious behavior/head trauma on 11/26/16, and nasal trauma/contusion on 12/15/16), Individual #19 (otitis on 10/21/16), Individual #139 (blepharitis on 11/5/16), Individual #46 (chest pain on 8/17/16, and shortness of breath on 9/8/16), Individual #48 (paronychia on 10/5/16, and skin alteration on 12/14/16), and Individual #59 (urinary retention on 9/20/16, and epistaxis on 9/16/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #46's shortness of breath on 9/8/16, and Individual #59's urinary retention on 9/20/16.

The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show 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 resolved or stabilized included those for Individual #61 (nasal trauma/contusion on 12/15/16), Individual #48's paronychia on 10/5/16, and Individual #59's urinary retention on 9/20/16.

The following provide some examples of problems noted:

- On 9/8/16, Individual #15 was discharged from the hospital with the diagnosis of community acquired pneumonia and acute constipation. On 9/8/16, the PCP conducted follow-up, but conducted no follow-up on 9/10/16, or 9/11/16. When the PCP conducted follow-up again on 9/12/16, the individual had elevated blood pressure and abdominal distention. The PCP ordered STAT clonidine for the elevated blood pressure. The individual's abdomen was moderately distended with slight tinkling sounds. The rectal exam was negative. The individual then had two episodes of emesis. An ultrasound of the gall bladder was ordered with a plan to follow up after the ultra sound. At 3:15 pm, the PCP documented no bowel movement in response to dulcolax and a negative gall bladder ultrasound. The assessment was abdominal distention with loss of appetite. The plan was to attempt an enema.

  On 9/13/16, the PCP documented that the KUB (abdominal x-ray) showed a markedly distended abdomen that was forming a volvulus. The sigmoid itself "is immensely dilated to the point of perforation." Emergency Medical Services (EMS) transferred Individual #15 to the ED, and he was admitted with a diagnosis of Ogilvie's syndrome. This individual had a moderately

distended abdomen with tinkling bowel sounds, emesis, loss of appetite, a history of electrolyte imbalance, and no response to acute measures. He also had just been discharged for similar problems. Evaluation at an acute care facility appeared warranted on 9/12/16.

- On 11/26/16, nursing staff documented that Individual #61 engaged in head banging that resulted in oral trauma and a scalp laceration. On 11/27/16, the neurological exam and neck exam the PCP conducted was incomplete. Similarly, on 12/15/16, after another individual punched Individual #61 in the face, the PCP did not conduct a neurological exam, even though nursing staff had implemented the head injury protocol.

  In terms of follow-up, on 11/27/16, the PCP noted a 1.5 x1 centimeter (cm) scalp laceration with bright red blood, but no active bleeding. The PCP documented that follow-up would occur the next day. On 11/28/16, the PCP noted that the laceration was bleeding and was repaired with dermabond. The plan was follow up in two days. No further follow-up was found in the records.
- On 11/5/16, nursing staff documented that Individual #139 had red sclera. Nursing assistant staff reported that there was "crusted stuff" in the individual's eye that was "yellow/green." The eye was washed prior to the nursing assessment. The plan was to refer the individual to the medical clinic or the on-call MD. There was no medical documentation for this event, but the Physician Orders included an order for eyelid scrubs, which was written on 11/5/16 at 2:16 p.m. for the diagnosis of blehparitis. On 11/14/16, another order was written for Vigamox for the diagnosis of conjunctivitis.
- For Individual #46's chest pain, no documentation was found to show that the on-call MD or PCP conducted an actual assessment of the individual. On 8/17/16 at 8:56 a.m., the PCP noted that: "the RN called me last night stating that client was c/o [complaining of] chest pain. She stated his vitals were stable and his electrocardiogram (EKG) showed sinus rhythm with 1st degree AV block with occasional PVCs." It was reported that the on-call MD ordered 81 milligrams (mg) aspirin times three at once. The plan was to repeat the EKG and compare it to the EKG of the previous night. However, there was no documentation of this in the record.
- For Individual #46's shortness of breath on 9/8/16, at 10:40 a.m., nursing staff documented that the individual was breathing heavy with hands pressed to his chest. Blood pressure was 95/49, pulse 66-70, oxygen saturations 94-95%, temperature 99.7, and respirations 16. Nursing staff's assessment noted crackles to the posterior lungs with diminished lung sounds (reported to normally be clear). At 12:15 p.m., the PCP noted that the individual refused assessment and went back to vocational education. A chest x-ray was ordered. On 9/9/16, the PCP noted that the chest x-ray was normal and pulmonary function tests would be ordered. The PCP conducted no further assessment of the individual. On 9/22/16, the pulmonary function tests were completed, and showed mild obstructive disease.
- On 9/16/16, the PCP documented that staff reported Individual #59 had a nosebleed since being released from his dental rehabilitation the day before. The physical exam revealed a small amount of bright red blood in the right nostril with no obvious bleeding site. The PCP documented that this was a traumatic injury related to anesthesia. The plan was to observe and follow-up on Monday if the bleeding persisted. The IPN documentation did not specify how nursing staff were to monitor for this and when PCP notification should occur. No documentation of follow-up was found. Nursing staff also documented that nursing assistant staff reported Individual #59 was stumbling and having difficulty speaking. The PCP did not address this in the PCP note. However, nursing staff documented that the PCP indicated that one-to-one supervision for medical observation would continue.

c. For three of the nine individuals reviewed, the Monitoring Team reviewed four acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #15 (hyponatremia on 10/14/16, and pneumonia and acute constipation on 9/2/16), Individual #46 (laceration on 8/23/16), and Individual #108 (sepsis on 8/23/16).

In its document request #15, the Monitoring Team requested: "For any individual with ED visits or Hospitalization, hospitalization records, including, for example, records that the hospital provided to the Facility, and related IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, labs, x-rays, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, ED notes, admit history and physical, consults, etc." In response, the Center submitted primarily Rio Grande State Center progress notes. The Monitoring Team informed the Settlement Agreement Coordinator (SAC) that submission of hospital records, such as admission history and physical, Discharge Summary, ED Notes, and transfer forms was required. The Center submitted additional records, but the comprehensive records requested were not always included.

In addition, the Center's response to document request #12 should have included all IPNs, but it often did not appear complete. For example, some IPNs were included in the Center's response to document request #15, but not #12. It was unclear from where these additional notes came. Scores are based on the IPN records as submitted in response to document request #12.

For Individual #108 (sepsis on 8/23/16), the transfer occurred after hours, but an IPN within one business day was not found. As discussed below, the PCP did not complete any evaluation or completed an incomplete evaluation of Individual #15.

f. It was positive that upon individuals' transfer to the ED or hospital, a provider or nurse communicated necessary clinical information with hospital staff.

d., e., g., and h. The following provide some examples of problems noted:

- On 10/14/16 at approximately 9:39 a.m., the PCP documented that Individual #15 was being sent to the ED for a sodium level of 119. The PCP reported that nursing staff indicated no change in behavior. However, the PCP did not conduct a face-to-face evaluation, even though this occurred during normal working hours. An additional IPN, written at 10:37 a.m. on 10/14/16, noted that on 9/6/16, after his hospitalization, the NaCl 1 gram (gm) twice a day (BID) was stopped and this was likely the etiology of severe hyponatremia. It should be noted that hospital records documented the likely cause of the hyponatremia was the combination of psychotropic agents, and a low sodium diet was also a contributing factor.

  On 10/20/16, a post-hospital assessment also noted that Individual #15's hypertension was stable on enalapril 40 mg each day. On 10/21/16, the PCP conducted follow-up to assess the individual who had a BP of 70/42, and pulse of 90. This was attributed to the change in enalapril dose that was 20 mg by mouth BID prior to hospitalization. (This would appear to be a problem with medication reconciliation post discharge.) There was no further follow-up related to the blood pressure. The next PCP entry on 10/26/16 was to document the sodium level of 132. In addition, this individual with chronic and severe hyponatremia had no documentation of a nephrology evaluation.
- On 9/1/16, the PCP documented that Individual #15 had an elevated blood pressure, had been complaining of a cough, and had several bowel movements. The individual's blood pressure was 169/102 and 144/104. The individual's abdomen was significantly distended and he looked uncomfortable. An EKG showed normal sinus rhythm with artifacts. The PCP suspected

that the cough and abdominal distention were GI related and the plan was to check an h pylori antigen. Enalapril was increased to 20 mg BID for blood pressure control. On 9/2/16 at 9:31 a.m., follow-up notes indicated that the abdomen was "still taut and distended with hypoactive bowel sounds." Labs and x-rays were ordered in addition to intramuscular (IM) Rochepn and a seven-day course of oral Bactrim. The individual had refused breakfast. The PCP noted that: "staff will alert weekend on call MD to monitor client over weekend." At 10:45 a.m., another PCP wrote: "visible worsening of distention over past hour and a half. Transfer to ER." On 9/1/16, the initial evaluation of this individual appeared incomplete. There was no rectal exam and no abdominal x-ray was ordered. Moreover, the PCP should have had direct communication (check-out system) with the physician that would be providing on-call coverage so that specific concerns were communicated. It was not appropriate to defer this to "staff."

On 9/8/16, the individual was discharged with the diagnosis of community acquired pneumonia and acute constipation. As discussed in further detail above, on 9/8/16, the PCP conducted follow-up, but conducted no follow-up on 9/10/16, or 9/11/16. When the PCP conducted follow-up again on 9/12/16, the individual had elevated blood pressure and abdominal distention. On 9/13/16, the PCP documented that the KUB (abdominal x-ray) showed a markedly distended abdomen that was forming a volvulus. The sigmoid itself "is immensely dilated to the point of perforation." Individual #15 was transferred to the ED per emergency medical staff (EMS) and admitted with a diagnosis of Ogilvie's syndrome. On 9/13/16, the IDT held an ISPA meeting, but the PCP was not in attendance.

- On 10/22/16, nursing staff documented that at around 9:00 p.m., Individual #108 tried multiple times to induce vomiting. Emesis was reported to occur several times. The on-call MD was notified and requested that staff observe this behavior. On 10/23/16, nursing staff documented that at 6:50 a.m., the individual had a blood glucose of 345. The individual's blood pressure was 79/39 and 83/51, heart rate 119, respirations 26, and oxygen saturation 98%. The individual appeared pale and drowsy. She "did not appear her usual self." The on-call MD was notified and gave orders to give insulin and encourage fluids. At 8:15 a.m., the individual's BP was 69/45 and 73/45, heart rate 110, respiration 20, and oxygen saturations 94%. The radial pulses were faint. The PCP was notified and requested transfer to the ED. The individual was admitted to the Intensive Care Unit (ICU) with a diagnosis of septic shock secondary to UTI. Despite the fact that this rapid deterioration at the Center was not addressed in a timely manner, no ISPA was submitted to show that the IDT had identified medical and healthcare supports to reduce the individual's risk and enhance early recognition.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Since the last review, improvement was noted in terms of PCPs reviewing consultations and indicating agreement or disagreement, doing so in a timely manner, and writing IPNs that included the necessary components. The Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and that IDTs review the recommendations and document their decisions and plans in ISPAs.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If individual has non-Facility consultations that impact medical care,	89%	2/2	2/2	1/2	2/2	2/2	2/2	1/2	2/2	2/2

	PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	16/18									
b.	PCP completes review within five business days, or sooner if clinically indicated.	94% 17/18	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
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.	94% 17/18	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	88% 14/16	2/2	2/2	N/A	1/2	2/2	2/2	1/2	2/2	2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	57% 4/7	2/2	N/A	N/A	N/A	1/1	N/A	0/1	1/2	0/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #15 for hematology on 11/9/16, and ophthalmology on 11/2/16; Individual #61 for neurology on 11/15/16, and eye on 1/12/17; Individual #27 for neurology on 1/16/17, and eye on 7/29/16; Individual #19 for neurology on 11/16/16, and nephrology on 10/26/16; Individual #139 for dental on 12/14/16, and dental on 7/11/16; Individual #46 for dental on 11/17/16, and eye of 11/16/16; Individual #48 for hematology on 10/3/16, and ear, nose, and throat (ENT) on 10/26/16; Individual #59 for podiatry on 9/20/16, and urology on 10/24/16; and Individual #108 for endocrinology on 12/27/16, and ENT on 10/17/16.

a. through c. It was positive that PCPs generally indicated agreement or disagreement with the recommendations in a timely manner, and wrote IPNs that included the necessary components. The exceptions were:

- The consultation for Individual #27 for eye on 7/29/16, for which no IPN was submitted; and
- The hematology consultation for Individual #48, for which the consultant noted the individual continued to have hypochromia and microcytosis with a hyper-segmented neutrophil. The hematologist recommend follow-up in six months, but the PCP disagreed without explanation and scheduled follow-up for one year.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written for all relevant recommendations, including follow-up appointments, with the exceptions of:

- For Individual #19 for nephrology on 10/26/16, the consultant noted that the individual's carbon dioxide (CO_2) was elevated on the metabolic panel, and an arterial blood gas (ABG) test might be needed if persistent to sort out the acid-base disorder. The CO_2 remained elevated and the PCP referred the individual to pulmonary for evaluation. However, an elevated CO_2 cannot be solely attributed to a respiratory acidosis, as metabolic alkalosis could also cause an increase.
- As noted above, the PCP did not provide an explanation for not following the hematologist's recommendation for Individual #48 to receive follow-up in six months.

e. Concerns included:

- When the PCP disagreed with Individual #48's hematology recommendation to follow-up in six months, it should have been referred to the IDT for discussion.

- On 10/24/16, an urologist saw Individual #59 and recommended that a cystoscopy be done to dilate a suspected urethral stricture. The PCP agreed with the recommendation, but did not refer the consult to the IDT for review. On 11/2/16, nursing staff noted that upon return from the hospital the individual was hyperactive, aggressive, and uncooperative. It would have been important for the PCP to meet with the IDT to make them aware of the nature of the procedure, and plan proper supports for his post-hospital return to the Center.
- Individual #108's ENT consultation identified that a decrease in hearing over the course of a year was associated with cerumen impactions and cotton balls in her ears. Reportedly, the cotton balls were from Q-tips that staff had used. However, the PCP did not refer this consultation to the IDT for follow-up.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: The Center should continue to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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.	56% 10/18	2/2	0/2	2/2	2/2	2/2	0/2	0/2	1/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #15 – cardiac disease, and GI problems; Individual #61 – osteoporosis, and other: hyponatremia; Individual #27 – seizures, and osteoporosis; Individual #19 – seizures, and other: hypothyroidism; Individual #139 – diabetes, and respiratory compromise; Individual #46 – respiratory compromise, and cardiac disease; Individual #48 – diabetes, and other: anemia; Individual #59 – other: anemia, and UTIs; and Individual #108 – cardiac disease, and diabetes).

a. For a number of individuals' chronic diagnoses and/or at-risk conditions, 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. The exceptions were: Individual #61 – osteoporosis, and other: hyponatremia; Individual #48 – diabetes; Individual #59 – other: anemia; and Individual #108 – cardiac disease. The following provide examples of concerns noted regarding medical assessment, tests, and evaluations:

- For Individual #61, the records did not reflect thorough assessment of the cause of hyponatremia. Additionally, there was no referral to nephrology for evaluation of long standing hyponatremia. There should be documentation that volume status and urine and serum electrolytes have been evaluated in an effort to determine the etiology. The PCP fully attributed this significant hyponatremia to the use of psychotropic medications, but did not mention discussing this with the psychiatrist to determine if alternative regimens were possible. The quarterly medical summary for January 2017 documented that Trileptal was being tapered due to hyponatremia. This was a potential adverse drug reaction, but was not reported as such.
- For Individual #61, on 1/7/15, a DEXA scan showed osteopenia of the lumbar spine and both hips, which worsened since

2011. The AMA also cited increased fracture risk due to recurrent falls. Her AMA indicated she was treated with calcium and Vitamin D, and bisphosphonates were not advisable due to a history of gastritis. The plan was to consider Prolia, if the next DEXA showed osteoporosis in 2018. However, given the abnormal DEXA in January 2015, a follow-up DEXA should have been completed in January 2017. In addition, the management of osteoporosis is not totally based on bone mineral density scores. Tools, such as the World Health Organization's validated Fracture Risk Assessment Tool (FRAX), incorporate non-bone mineral density clinical risk factors into the assessment of an individual's fracture risk and the need for pharmacologic therapy, but such a tool had not been applied to Individual #61.

- Per Individual #48's AMA, he was at low risk for diabetes mellitus and metabolic syndrome: "not an active diagnosis. HbA1c [Hemoglobin A1C] is normal at 5.5. Lipid panel is now normal on Omega 3 supplementation and no longer considering Niacin due to history of intolerance." The risk rating for this individual should be reviewed. He was being treated for dyslipidemia, had an HbA1c that was at the upper limits of normal (5.7 to 6.4 is pre-diabetes), and was prescribed risperidone (i.e., a new generation anti-psychotic). The HbA1c level was obtained in May 2016, and was very close to the range for pre-diabetes. Given the risks such as hyperlipidemia and the use of next generation antipsychotics, close follow-up is warranted and appropriate lifestyle and pharmacologic interventions should be implemented consistent with American Diabetes Association (ADA) guidelines.
- On 7/12/16, Individual #59 had a hemoglobin (Hb) of 13.7 with a mean corpuscular volume (MCV) of 97 and red blood cell distribution width (RDW) of 14. Per the AMA, the individual had not had any reported rectal bleeding and was not yet due for an esophagogastroduodenoscopy (EGD) or colonoscopy. Iron supplementation was started, and the plan was to monitor the complete blood count (CBC) every three months for temporal stability. However, the red blood cell indices for this individual did not point towards iron deficiency. There was no evidence that initial steps of anemia evaluation were done, such as review of the peripheral blood smear. Additional studies should be based on the findings of the smear, and the reported red blood cell indices.

  The evaluation of anemia is generally straightforward, and the approach to the evaluation of an adult with unexplained anemia is found in numerous texts. It is important that a proper evaluation be completed. Supplemental iron should be prescribed for an individual with documented iron deficiency. Moreover, when an individual is determined to be iron deficient, the etiology must be determined. It is particularly important to identify the source of iron loss in adults who have no obvious source of iron loss, such as menses.
- Individual #108 was at high risk for hyperlipidemia, hypertension, and coronary artery disease. The AMA did not document proven coronary artery disease. The AMA included the diagnoses of hypertension, low ejection fraction (EF), and hyperlipidemia. The PCP had not calculated a cardiovascular risk score to determine if high-dose statins were appropriate.

  According to the AMA, the individual's hypertension was managed with angiotensin-converting enzyme inhibitors (ACE)/ angiotensin-receptor blockers (ARB). In 2013, the echocardiogram (EKG) showed an EF of 40 to 50 percent. However, there was no explanation for the reduced ejection fraction. The AMA set a goal of improving the EF to 55 to 70 percent. A repeat echocardiogram would be needed to make this determination, but the records did not provide evidence of a follow-up study. The cardiac consult provided no information related to cardiac dysfunction, citing diagnoses of abnormal EKG, hyperlipidemia, hypertension, and diabetes mellitus type 2. The consult request stated the follow-up was for an abnormal EKG and did not mention the decreased EF noted in the AMA. The last EF was documented in 2013. The individual was reported to be

asymptomatic. The action steps in the IHCP included weekly assessments of vital signs, heart sounds, carotid arteries, femoral arteries, pedal pulses, and extremities. These action steps were assigned to the floor nurses.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Although PCPs often implemented action steps assigned to them, IHCPs generally did not include a full set of action steps to address individuals' medical needs. The Monitoring Team will continue to review this indicator.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	78% 14/18	2/2	2/2	2/2	2/2	2/2	1/2	1/2	1/2	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 often were implemented.											

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; recommendations are made about any necessary additional laboratory testing 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.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not Rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
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.

Summary: Given the timely practitioner review of QDRRs (Round 9 – 100%, Round 10 – 100%, and Round 11 – 97%), indicator c will be placed in the category requiring less oversight. The Center should focus on the timely completion and quality of QDRRs. As these improve, the Center should maintain its performance with regard to the implementation of the agreed-upon recommendations.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	QDRRs are completed quarterly by the pharmacist.	22% 4/18	0/2	0/2	0/2	0/2	0/2	0/2	2/2	0/2	2/2
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;	28% 5/18	0/2	0/2	2/2	2/2	0/2	1/2	0/2	0/2	0/2
	ii. Benzodiazepine use;	70% 7/10	1/2	2/2	N/A	N/A	1/2	1/2	N/A	2/2	N/A
	iii. Medication polypharmacy;	100% 14/14	2/2	2/2	2/2	2/2	2/2	2/2	N/A	2/2	N/A
	iv. New generation antipsychotic use; and	17% 2/17	0/2	0/2	0/2	N/A	N/A	2/2	0/2	0/2	N/A
	v. Anticholinergic burden.	79% 11/14	2/2	1/2	2/2	N/A	1/2	2/2	1/2	2/2	N/A
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.	94% 17/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	1/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 14/14	2/2	2/2	2/2	N/A	2/2	2/2	2/2	2/2	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 10/10	1/1	1/1	2/2	1/1	N/A	1/1	1/1	2/2	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									

Comments: b. As the physician member of the Monitoring Team discussed with the Pharmacy Director and the Medical Director while on site, concerns with regard to the QDRRs included:

- In completing the QDRRs, the Clinical Pharmacist was not consistently using the correct definition of metabolic syndrome, and/or was not reviewing the five criteria of metabolic syndrome. For example, the use of next generation antipsychotics (NGAs) was listed as a risk factor in some cases. However, the use of NGAs is not one of the five risk factors used as criteria in diagnosing metabolic syndrome. As a result, individuals with risk factors were not correctly identified as having or not having metabolic syndrome, and/or being at risk for it (e.g., Individual #15, Individual #61, Individual #27, Individual #48, and Individual #59). Even if the individual does not have three of the five criteria necessary to diagnose metabolic syndrome, identification of risk is important. Appropriate risk mitigation should occur in order to prevent/delay progression to metabolic syndrome and/or diabetes mellitus.
- In addition, the Medical Department was not consistently calculating atherosclerotic cardiovascular disease (ASCVD) risk. This impacted the Pharmacy's ability to accurately calculate the individual's risk factors for metabolic syndrome, as well as determine the intensity of statin therapy. When individuals did not have this risk calculated (e.g., Individual #15, Individual #46, Individual #48, and Individual #59), the Clinical Pharmacist should have recommended the PCP calculate the risk, but did not.
- Some individuals (e.g., Individual #46, Individual #48, and Individual #59) were prescribed iron with no explanation for why their iron was low (i.e., occult GI cancers could be an underlying and undetected cause). The Clinical Pharmacist should have been identifying these concerns and making recommendations, but was not doing so.

Other concerns included:

- At times, the Clinical Pharmacist correctly identified the use of benzodiazepines, but provided no comments on their use (e.g., Individual #139).
- Similarly, in some cases, the Clinical Pharmacist correctly identified the use of medications that contribute to anticholinergic burden, but provided no assessment of the burden (e.g., Individual #139, and Individual #48).
- The Clinical Pharmacist did not consistently comment on abnormal laboratory findings (e.g., hyponatremia for Individual #15, elevated prolactin and glucose levels for Individual #139, Vitamin D level for Individual #46, elevated Hemoglobin A1C for Individual #48, and supratherapeutic Vitamin D level for Individual #59).
- The Clinical Pharmacist sometimes did not comment on the use or effectiveness of STAT medications (e.g., Individual #46, and Individual #15).
- For Individual #108, conditions requiring multiple medications did not have adequate comments. For example, the diagnosis of diabetes mellitus requires monitoring in several areas. Measurement of urinary protein is important in assessing renal damage. The diagnosis of hypertension also requires monitoring of urinary protein and electrocardiogram, etc. The evaluation did not address these needed labs.

c. and d. For the individuals reviewed, it was good to see that prescribers were generally 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.											
Summary: For individuals reviewed, IDTs often did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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	0/1	0/1	0/1	1/1	0/1	1/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	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% 0/9	0/1	0/1	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% 0/9	0/1	0/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings. The goals/objectives that were clinically relevant, achievable, but not measurable were the SAPs for Individual #46 (i.e., brushing and flossing), Individual #59 (i.e., brush teeth with hand-over-hand assistance and return demonstration), and Individual #108 (i.e., allowing staff to brush her teeth). 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 a timely and 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. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provision of dental supports and services.											

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: These are new indicators, which the Monitoring Team will continue to review.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individuals have no diagnosed or untreated dental caries.	75%	0/1	1/1	0/1	N/A	1/1	1/1	1/1	1/1	1/1

		6/8									
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/R
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	33% 1/3	N/R	0/1	0/1	N/R	N/R	1/1	N/R	N/R	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: b. When individuals' exams identified them as having periodontal disease, but no periodontal probing and/or x-rays were available for two consecutive exams, the Monitoring Team could not rate this indicator (e.g., Individual #15, Individual #19, Individual #139, Individual #48, and Individual #59). The Monitoring Team is applying the "N/R" score to this round of reviews to allow State Office to work with the Centers to improve practice. However, beginning in the next round of reviews, if an individual should have had periodontal charting and/or x-rays, and they were not completed, or a justification is not provided for a lack of completion, then these scores will be scored 0.

c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.

Summary: Over this review and the last review period, individuals and/or their staff generally received tooth-brushing instruction from Dental Department staff at preventative visits, and generally received necessary dental x-rays. If the Center maintains its performance on these indicators, after the next review, Indicators b and c might move to the category requiring less oversight. The Center needs to focus on the provision and quality of other dental treatment.

Individuals:

#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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, unless clinically justified.	44% 4/9	0/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental	89%	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

	Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	8/9									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	33% 3/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	0% 0/2	N/R	N/A	N/R	N/A	N/A	0/1	0/1	N/A	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: Overall, there appeared to be problems with the provision of adequate daily oral care. The records frequently documented that individuals presented to the clinic for dental rehearsals with food impactions and evidence of a lack of proper home oral care. The Center should focus on improving individuals' daily oral care. In addition, it was also not clear how the behavioral health services staff were assisting in addressing barriers to the provision of dental services.

f. Individual #15's need for restorative work was unknown. His annual exam, dated 8/29/16, showed heavy plaque and calculus, as well as moderate to severe inflammation with bleeding upon brushing. Dental caries were documented as "?," and the dentist made a recommendation for an exam and treatment under general anesthesia. However, no additional treatment was provided and/or documented in 2016.

On 11/30/16, Individual #27 had caries identified, and she was pending treatment.

For Individual #46, in September 2015, the dentist identified multiple caries and "rampant decay." In February 2016, rampant decay was noted again, and some fillings and extractions were completed. There were no records beyond this point, and it was not clear that the rampant decay had been fully addressed.

In August 2015, the dentist noted "rampant decay" in Individual #48's teeth, but it was not until September 2016 that restorations were completed.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is	N/A									

	provided.										
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
	Comments: a. through c. None of the individuals the Monitoring Team reviewed had experienced dental emergencies within the six months prior to the review.										

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Center had not made progress on these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/7	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	0% 0/1		N/A	N/A	0/1	N/A		N/A	N/A	N/A
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/1		N/A	N/A	0/1	N/A		N/A	N/A	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	N/A	0/1	N/A		N/A	N/A	N/A
	Comments: a. For a number of individuals (i.e., Individual #61, Individual #48, Individual #59, and Individual #108), assessment of the need for suction tooth brushing was not found. The dentist indicated that Individual #139 needed suction tooth brushing. However, it was not discussed/included in his IHCP, and the Center's response to the document request indicated it was not needed.										

Outcome 9 – Individuals who need them have dentures.											
Summary: Improvements are needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	17% 1/6	0/1	N/A	N/A	0/1	0/1	1/1	N/A	0/1	0/1
b.	If dentures are recommended, the individual receives them in a	0%	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A

	timely manner.	0/1									

Comments: a. For a number of individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding dentures.

b. Starting in March 2016, Individual #46 had impressions made. In January 2017, he had a final impression/fitting done. This was in part due to the fact that the dentist did not feel he would adjust well to dentures, but Individual #46 wanted them.

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.

Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. For the acute care needs reviewed, nursing staff had developed acute care plans, which was positive. It was also good that one met criteria. However, substantially more work is needed to ensure all acute care plans meet individuals' needs, and that they are implemented. These indicators will remain in active oversight.

			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	56% 5/9	1/1	N/A	N/A	0/2	0/1	2/2	1/1	0/1	1/1
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.	33% 3/9	0/1			0/2	0/1	1/2	1/1	0/1	1/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	30% 3/10	0/2			0/2	1/1	1/2	0/1	0/1	1/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	50% 1/2	0/1			N/A	N/A	1/1	N/A	N/A	N/A
e.	The individual has an acute care plan that meets his/her needs.	10%	0/2			0/2	0/1	1/2	0/1	0/1	0/1

		1/10										
f.	The individual's acute care plan is implemented.	20% 2/10	0/2			0/2	1/1	1/2	0/1	0/1	0/1	

Comments: The Monitoring Team reviewed 10 acute illnesses and/or acute occurrences for seven individuals, including Individual #15 – hyponatremia with risk of fluid volume deficit on 12/12/16, and urinary tract infection (UTI) on 7/17/16; Individual #19 – otitis externa on 12/17/16, and UTI on 9/8/16; Individual #139 – conjunctivitis on 11/15/16; Individual #46 – herpes zoster on 11/8/16, and laceration to right arm on 8/24/16; Individual #48 – paronychia on 10/3/16; Individual #59 – impaired urinary elimination on 10/6/16; and Individual #108 – UTI on 9/7/16.

For Individual #15, an acute care plan was initiated after results of lab testing showed hyponatremia, so Indicators a and b were not applicable.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #46 – laceration to right arm on 8/24/16, Individual #48 – paronychia on 10/3/16, and Individual #108 – UTI on 9/7/16.

c. Ongoing nursing assessments were completed for: Individual #139 – conjunctivitis on 11/15/16, Individual #46 – herpes zoster on 11/8/16, and Individual #108 – UTI on 9/7/16.

d. Licensed nursing staff conducted pre- and post-hospitalization assessments for Individual #46 – laceration to right arm on 8/24/16.

e. It was positive that the acute care plan that nurses developed for Individual #46's laceration to the right arm, dated 8/24/16, met his needs. Common problems with the remaining acute care plans reviewed included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (the exceptions were Individual #15 – hyponatremia on 12/12/16, Individual #139 – conjunctivitis on 11/15/16, Individual #46 – herpes zoster on 11/8/16, and Individual #48 – paronychia on 10/3/16); alignment with nursing protocols (the exceptions were Individual #139 – conjunctivitis on 11/15/16, and Individual #46 – herpes zoster on 11/8/16); specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur (the exceptions were Individual #46 – herpes zoster on 11/8/16, and Individual #48 – paronychia on 10/3/16).

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

- Despite the fact e coli was found in the urinalysis, Individual #15's acute care plan for his UTI on 7/17/16 did not address hygiene issues, nor did the nursing assessments in the progress notes comment on hygiene. In addition, a number of the interventions in the acute care plan were not measurable (e.g., encourage fluids, encourage individual to void frequently), and at times, the frequency of interventions was not stated.
- On 9/7/16, as staff were bringing Individual #19 to the restroom, she urinated and the urine smell was "very strong, fishy, and foul smelling… VS [vital signs] not done at this time as she was already going to the shower." The nurse did not conduct and/or document an assessment. A progress note indicated Individual #19 was placed on the clinic concern list, but the nurse did not notify the PCP of the individual's symptoms. The PCP did not see Individual #19 until 9/8/16 at 6:45 p.m. The acute care plan did not include specific nursing assessments for UTIs.

- For Individual #139's conjunctivitis, no progress notes were found showing that a nurse initially assessed him when he had discharge from both eyes, or notified the PCP. However, once the individual was diagnosed with conjunctivitis, nurses conducted ongoing assessments that were consistent with current standards of practice, even though the acute care plan did not include a full set of measurable interventions.
- It was positive that on 8/24/16, nurses assessed Individual #46's laceration to the right arm, and notified the PCP. The nurses also completed pre- and post-hospitalization assessments consistent applicable standards, and developed a good acute care plan. Some assessments of the laceration that nurses documented in the progress notes were exceptional in terms of describing the laceration in order to gauge progress of healing. However, other documentation of assessments did not include a description of the laceration or the presence of sutures.
- On 9/20/16, a PCP progress note indicated Individual #59 was having problems urinating. No nursing notes indicating assessments were completed were found between this date and 10/6/16, when nursing staff initiated an acute care plan. Moreover, the acute care plan that nursing staff developed did not provide complete assessment criteria.
- For Individual #108, missing interventions in the acute care plan increased her risk for a UTI. More specifically, she is catherized regularly, and nurses need to conduct the intervention using strict sterile procedures, but the acute care plan did not specify this requirement. In addition, some interventions did not include the frequency or were not measurable (e.g., encourage fluids).

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.

Summary: For individuals reviewed, IDTs did not have a way to measure outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 15	61	27	19	139	46	48	59	108
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	0/2	0/2	0/2	0/2	0/2	1/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	1/2
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 #15 – falls, and dental; Individual #61 – constipation/bowel obstruction, and dental; Individual #27 – weight, and dental; Individual #19 – fractures, and weight; Individual #139 – falls, and dental; Individual #46 – constipation/bowel obstruction, and

weight; Individual #48 – dental, and cardiac disease; Individual #59 – constipation/bowel obstruction, and behavioral health; and Individual #108 – dental, and falls).

The goal/objective that was clinically relevant, but not measurable was for dental for Individual #108.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #27 – weight, and Individual #108 - falls.

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.											
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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% 0/17	0/2	0/2	0/2	0/2	0/2	0/2	0/1	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 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. through c. As noted above, for six individuals' medium and high mental health and physical health risks, IHCPs defined the nursing assessments that nurses should complete to address their needs. However, evidence generally 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.											
Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following infection control procedures (g, and previously f). However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual receives prescribed medications in accordance with applicable standards of care.	89% 16/18	2/2	0/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	Medications that are not administered or the individual does not accept are explained.	71% 5/7	1/1	0/2	1/1	N/A	N/A	1/1	1/1	1/1	N/A
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).	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	N/R									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	N/R									

e.	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.	100% 6/6	N/A	N/A	2/2	1/1	N/A	1/1	N/A	1/1	1/1
f.	Individual's PNMP plan is followed during medication administration.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
g.	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
h.	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
i.	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
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	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									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	60% 3/5	1/1	0/1	N/A	0/1	1/1	1/1	N/A	N/A	N/A
m.	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.	0% 0/2	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A

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

a. through c. For Individual #61, the nurse on the Monitoring Team observed medication administration on two separate days. For both medication administration observations (noon and 8 p.m.), the medication nurses gave Individual #61 medication before the prescribed timeframes. When asked why they were giving the individual her medications early, both medication nurses indicated independently that if they did not give her the medications when she wanted them, she would exhibit unwanted behaviors. Both medication nurses indicated that they recognized that this early medication administration was a medication variance, but they had not been reporting the variances. Consequently, the practice of giving Individual #61 her medications at non-prescribed times to avoid behavior issues had been ongoing for a significant period of time. However, the Center's medication administration audits had not identified this as a problem. Also, there was no indication that Behavior Health Services staff and nursing staff had collaborated on this issue. Further, a review of the Medication Administration Records (MARs) did not indicate that any medications were given outside of the prescribed timeframes. No variance forms were provided to show that Individual #61 was receiving her medications outside the prescribed timeframes. This called into question the accuracy of the MARs. An ISPA, dated 12/1/16, noted that floor nurses should not be giving Individual #61 items just to avoid a behavior, which indicated that that nursing staff were using unapproved strategies with her.

d. The Monitoring Team is not rating these indicators yet to provide time for the Centers to train staff. It is anticipated that by April

2017, training will be completed.

e. For the individuals reviewed, when nursing staff administered PRN medication, they documented the reason, route, and the individual's reaction or the effectiveness of the medication.

f. It was positive that for most of the individuals with PNMPs that the Monitoring Team observed, nursing staff followed the PNMPs. For Individual #108, the nurse did not follow the procedure in the PNMP to have the individual take two swallows and then check for pocketing of pills.

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

h. 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.

i. 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.

l. and m. As noted above, nurses were not reporting what appeared to be frequent medication variances for Individual #61.

For Individual #19, documentation provided indicated that in August 2016, a number of missing signatures were found during random checks of the MAR/Treatment Administration Record (TAR). Although the documentation indicated that training was conducted on the most current Medication Variance policy, no variance forms were provided for the missing documentation.

Also of note, during the observation of a medication pass for Individual #139, a direct support staff person held his arms, which is a form of restraint. At the time, the individual was not a danger to himself or others, so it was an inappropriate use of restraint. When the direct support staff person suggested to the nurse that she let Individual #139, who is visually impaired, smell the pudding, this appeared to signal to him that it was time for his medications, and he stopped struggling and opened his mouth. Nursing staff should work with Behavioral Health Services staff and/or Habilitation Therapies staff to identify strategies that will facilitate Individual #139's medication administration.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.	
Summary: The Center needs to continue to focus on ensuring individuals' IDTs refer them to the PNMT, as appropriate, or that the PNMT makes self-referrals. Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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;	8% 1/12	N/A	0/2	0/2	0/1	0/1	0/1	0/2	1/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12		0/2	0/2	0/1	0/1	0/1	0/2	0/2	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12		0/2	0/2	0/1	0/1	0/1	0/2	0/2	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12		0/2	0/2	0/1	0/1	0/1	0/2	0/2	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12		0/2	0/2	0/1	0/1	0/1	0/2	0/2	0/1
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;	67% 4/6	2/2	N/A	N/A	0/1	1/1	0/1	N/A	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	17% 1/6	1/2			0/1	0/1	0/1			0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	67% 4/6	2/2			0/1	1/1	0/1			1/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6	0/2			0/1	0/1	0/1			0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6	0/2			0/1	0/1	0/1			0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/2			0/1	0/1	0/1			0/1
Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that eight individuals' IDTs were responsible for developing. These included goals/objectives related to: GI problems, and falls for Individual #61; choking, and falls for Individual #27; aspiration for Individual #19; choking for Individual #139; aspiration for Individual #46; choking, and aspiration for Individual #48; choking, and falls for Individual #59; and falls for Individual #108.											

a.i. and a.ii. Individual #59's IDT developed an IHCP for choking with a clinically relevant goal/objective. The goal appeared to address an underlying cause of his choking risk, namely eating too quickly. The goal incorporated using a napkin or taking a drink to slow his eating pace. Unfortunately, the goal was not designed as a measurable SAP on which staff could take data to allow the IDT to determine whether or not Individual #59 successfully slowed his eating pace. The IDT was moving in the right direction, though, which was good to see.

b.i. The Monitoring Team reviewed six areas of need for five 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 goals/objectives were included. These areas of need included: weight, and skin integrity for Individual #15; weight for Individual #19; weight for Individual #139; falls for individual #46; and weight for Individual #108.

These individuals should have been referred or referred sooner to the PNMT:

- Individual #19 was enterally fed. Between August 2015 and October 2016, she gained 25 pounds, and had a body mass index of 50.66, placing her in the morbidly obese category. In August 2015, she weighed 177 pounds. In October 2016, she weighed 202 pounds, and she appeared to have stabilized at that weight. However, in July and August 2016, she reached a high of 207 to 209 pounds. There were not significant fluctuations that would suggest changes in fluid retention, though fluid retention was an identified issue and she had swelling in her lower extremities, which were elevated off and on throughout the day in her wheelchair. At various points during this trajectory, her IDT should have referred her to the PNMT, or the PNMT should have made a self-referral.
- Individual #46 re-fractured his left ulna, but the IDT did not refer him to the PNMT for this fracture of a long bone.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT developed clinically relevant, achievable, and measurable goals/objectives for skin integrity for Individual #15. More specifically, the PNMT worked with the IDT to develop goals/objectives to get him up and moving, and reduce his time in bed secondary to a UTI and possibly dementia.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: weight for Individual #15, weight for Individual #139, and weight for Individual #108.

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.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	15	61	27	19	139	46	48	59	108

		Score									
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% 0/16	0/2	0/2	0/2	0/2	0/2	0/2	0/2	N/A	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.	38% 3/8	2/2	N/A	0/1	0/1	0/1	1/2	N/A	N/A	0/1
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.

b. The following provide examples of concerns related to IDTs' responses to changes in individuals' PNM status:

- Individual #27 experienced seven falls, but there was limited evidence that the IDT met to review falls, and implement strategies to prevent them and protect her. On 10/18/16, the IDT met for her ISP meeting and the RN Case Manager requested a shower chair and a helmet, which the OT/PT had not identified as needs in their screening. During an ISPA meeting on 1/6/17, the RN stated they were still waiting for the helmet. At the time of the Monitoring Team's onsite review, Individual #27 was wearing a helmet. The ISPA, dated 1/6/17, indicated that PT services had been discontinued in October, because she had met a third of her goals, but there was no evidence of an ISPA at that time. This was also true for PT services discontinued related to a recumbent bike program and walking program. In addition, the evidence of progress related to PT services was poorly documented, and as such, rationale for discontinuation was not well supported.
- As discussed with regard to Outcome #2, Individual #19's IDT did not refer her to the PNMT to address her weight gain and morbid obesity, which potentially impacted her other health risks.
- Although Individual #46's IDT met to discuss his falls, they did not identify and/or develop comprehensive strategies to address the cause(s) of his falls.
- Individual #108's IDT did not refer her timely to the PNMT to address her weight loss.

c. For Individual #15, the discharge ISPA did not summarize strategies to continue related to weight maintenance. It also did not summarize the service objective designed to keep him moving and prevent future skin breakdown. No data collection was described, but the December 2016 ISPA just indicated that he should continue for six more months.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: Although these scores showed improvement since the last review, during numerous observations, staff still failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and	

reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should continue its efforts to determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.		
#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	53% 24/45
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.	100% 4/4
Comments: a. The Monitoring Team conducted 45 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during one out of two observations (50%). Staff followed individuals' dining plans during 22 out of 38 mealtime observations (58%). Transfers were completed correctly one out of five times (20%).		

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.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. None.											

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.											
Summary: Overall, IDTs did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/4	0/1	0/1	0/1	0/1	N/A	N/A	N/A	N/A	N/A

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Individual has made progress on his/her OT/PT goal.	0% 0/4	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% 0/4	0/1	0/1	0/1	0/1					

Comments: a. and b. Individual #46, Individual #48, Individual #59, and Individual #108 had functional motor and self-help skills, so a goal/objective was not indicated. Individual #139's OT/PT evaluation was conducted after his ISP meeting, but it was unclear why the IDT requested the consult.

c. through e. As noted above, Individual #46 had functional motor and self-help skills. He was part of the outcome group, so further review was not conducted. Individual #48, Individual #59, and Individual #108 were part of the core group, and so the Monitoring Team conducted full monitoring of their supports and services. For the remaining four individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives to address areas of OT/PT need, and/or because clear documentation was not provided regarding whether or not the individual had OT/PT needs (i.e., Individual #139).

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/2	N/A	N/A	0/1	0/1	N/A	N/R	N/A	N/A	N/A
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% 0/1			0/1	N/A					

Comments: a. The only data submitted for Individual #19's leg exercises and leg elevation was from October and December 2016.

For Individual #27, very limited documentation was found to confirm the provision of services. An IPN written in November 2016 did not identify the number of treatments provided. Another IPN in December provided no data and no documentation of frequency of treatment provided.

b. For Individual #27, there was no evidence of an ISPA meeting to discontinue the recumbent bike program, and no evidence of a timely ISPA meeting to discontinue direct PT services. An ISPA, dated 1/6/17, stated that Individual #27 had met a third of her goals in

October 2016, and PT services were discontinued at that time, but no corresponding ISPA was submitted.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: During this review and the last one, the Center's performance related to the cleanliness and working order of adaptive equipment improved. At the time of the next review, if the Center has sustained this level of performance, then Indicators a and b might move to the category requiring less oversight. Given its importance to the health and safety of individuals, the Center should focus on ensuring individuals have equipment that fits them. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.			Individuals:								
#	Indicator	Overall Score	19	51	140	4	85	115			
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			

Comments: a. According to his PNMP, Individual #115 was supposed to wear ankle and foot orthoses (AFOs), but he was not wearing them. The Monitoring Team conducted observations of five pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

b. It was positive that the equipment observed was in working order.

c. Based on observation of Individual #19, Individual #51, and Individual #140 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center'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.

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. No indicators had sustained high performance scores to be moved the category of requiring less oversight.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Regarding the ISP goals and action plans, the Monitoring Team found the lack of implementation, monitoring, and reliable and valid data to be significant concerns. It was positive that most staff knew the preferences of individuals, but staff knowledge regarding individuals' ISPs was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation.

Attending to the status of SAPs is a focus area for Rio Grande SC. Most SAPs were not making progress, however, none had reliable data. Further, the content of the written SAPs was incomplete for all SAPs. A common missing component was the absence of clear SAP training instructions and a data collection system that was in line with the training methodology.

SAPs that were observed by the Monitoring Team were not done correctly and the facility did not have a plan to regularly assess the quality of implementation. Without correct implementation, learning is not likely to occur and instead, valuable staff and individual personal time are wasted.

Overall, engagement levels were low. Improvement is needed, perhaps by focusing on some of the individuals who did not attend any of the vocational or day activities offered by the Center. Their activity could be best described as wandering around their homes.

For individuals who received educational services from the local public school district, educational services were not integrated into the current ISP.

For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

Since the last review, improvement was noted with regard to individuals having access to and using AAC/EC devices functionally. However, IDTs generally did not have a way to measure clinically relevant outcomes with regard to individuals' communication skills.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Although some goals were individualized, they did not meet criterion with ISP indicators 1-3 and, thus, the indicators of this outcome also did not meet criteria. Specifically, the goals that were developed did not have data to allow progress to be assessed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
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: As Rio Grande SC further develops individualized personal goals, it should focus on developing actions plans that clearly support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators. Examples of how this might be accomplished are provided above. 4-7. A personal goal that meets criterion for outcomes 1 through 3 is a pre-requisite for evaluating whether progress has been made. None of the personal goals met criterion for Indicators 1 through 3 as described above, therefore, there was no basis for assessing progress in these areas. The Monitoring Team found the lack of implementation, monitoring, and reliable and valid data to be significant concerns.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	140	147	15	61	27	48			
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. It was positive that most staff knew the preferences of individuals, but staff knowledge regarding individuals' ISPs was insufficient											

to ensure its implementation, based on observations, interviews, and lack of consistent implementation. Examples included:

- Individual #15's PNA was not familiar with his fluid restriction and could not articulate the need for cleaning under the foreskin of his penis as it related to his risk of UTI. Nursing staff knew his health issues, but did not track his fluid intake as needed.
- Individual #147's PNA did not know about his token economy program. When asked about areas of risk, or things staff need to know about keeping him safe and healthy, the PNA stated he did not have any medical issues and did not articulate his medium risks for choking, aspiration, and weight.
- Individual #48's PNA was familiar with his dining needs and aspiration risk, but less so with the specifics of his PBSP. The PNA was not familiar with his SAPs, indicating many had just changed. She mentioned brushing teeth, grooming, and putting on socks, but no evidence indicated he had the latter two programs.

40. Action steps were not consistently implemented for any individuals, as documented above.

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.											
Summary: Attending to the status of SAPs is a focus area for Rio Grande SC. Without useable data, it will be impossible to meet criteria with this outcome. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
6	The individual is progressing on his/her SAPS	0% 0/23	0/2	0/3	0/3	0/3	0/3	0/1	0/2	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	N/A	N/A	N/A	N/A	N/A	0/2	N/A
8	If the individual was not making progress, actions were taken.	0% 0/11	N/A	0/2	0/2	0/3	0/1	0/1	0/2	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	24% 4/17	N/A	1/3	0/2	0/3	2/3	0/1	0/2	1/3	N/A

Comments:
6. The majority of SAPs (e.g., Individual #15's brush teeth SAP) were scored as not meeting criterion because they were not making progress. Additionally, some SAP data did indicate progress (e.g., Individual #81's use oven mitts SAP) and others did not have data (e.g., Individual #49 operate the clothes dryer SAP), however, all were scored as not making progress because they did not have reliable data (see indicator #5).

7. The objectives for Individual #61's point to her medication SAP and identify healthy foods SAP were achieved, but a new step/objective was not introduced.

8. None of the 11 SAPs judged as not progressing (e.g., Individual #147's point to his medication 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 evidence of data based decisions to continue, discontinue, or modify SAPs for 24% of SAPs (e.g., Individual #140 was progressing in her teeth brushing SAP, and training was continuing).

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: Much continued work is needed in this area, particularly in specifying the instructions for staff implementation (i.e., training instructions). This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
13	The individual's SAPs are complete.	0% 0/23	0/2	0/3	0/3	0/3	0/3	0/1	0/2	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 23 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, or total task training procedures. However, neither the SAP training sheet nor the SAP data sheet indicated the current training step.

In observing SAPs and talking to staff, it appeared that the training procedure for the majority of SAPs was total task, regardless of the stated training methodology.

Additionally, the data system for the majority of SAPs was to record the highest level of prompt necessary to complete the task. There was no evidence that any SAPs included data concerning the specific steps for which the individual was requiring additional prompts.

Outcome 5- SAPs are implemented with integrity.											
Summary: SAPs that were observed by the Monitoring Team were not done correctly and the facility did not have a plan to regularly assess the quality of implementation. Without correct implementation, learning is not likely to occur and instead, valuable staff and individual personal time are wasted. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
14	SAPs are implemented as written.	0% 0/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A	0/1

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% 0/23	0/2	0/3	0/3	0/3	0/3	0/1	0/2	0/3	0/3

Comments:
14. The Monitoring Team observed the implementation of three SAPs. Two of them, Individual #62's request water SAP and Individual #44's sort clothes were not implemented as written. The third, Individual #15's turn on the radio SAP, could not be completed because staff could not find his radio.

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, Rio Grande SC 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 data are graphed.

Summary: It was good to see that many SAPs included graphs of performance. Overall low scores for both indicators occurred for both indicators for this review, and for the last review, too. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 114	140	49	44	81	147	15	61	62
16	There is evidence that SAPs are reviewed monthly.	4% 1/23	0/2	0/3	0/3	0/3	0/3	1/1	0/2	0/3	0/3
17	SAP outcomes are graphed.	70% 16/23	0/2	2/3	2/3	3/3	3/3	1/1	2/2	3/3	0/3

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports, however, for all individuals other than Individual #147, these reviews were five or more months old, indicating that monthly reviews were not regularly occurring.

17. Of the 17 SAPs with data only Individual #140's use a knife to cut her food SAP was not graphed.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.

Summary: Overall, engagement levels were low, as evidenced by indicator 18, which also scored the same as at the last review. Improvement is needed, perhaps by focusing on some of the individuals who do not attend any of the vocational or day activities offered by the Center. The facility was regularly measuring engagement and had set goals. Therefore, with sustained high performance, indicators 19 and 20 might move to the category of requiring less oversight after the next review. Achieving those goals had improved since the last review. All four

Individuals:

indicators will remain in active monitoring.											
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	1/1	1/1	0/1	0/1	0/1	0/1	0/1	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.	33% 3/9	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1

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 two individuals (Individual #114, Individual #140, Individual #81) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

During the day hours, about half of the individuals attended the vocational and day activity area. Some individuals were engaged in activities in this area, but many were not. Almost all of the individuals who did not attend the vocational and day activity area were not engaged. Their activity could be described as wandering around their homes.

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. Three individuals (Individual #114, Individual #81, Individual #62) 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.											
Summary: Community outings occurred, but did not meet criteria for this indicator. Community SAP training occurred for some individuals, but also did not meet criteria. It was good to see that outings were occurring. With additional work, it is likely that the facility can make progress on these indicators. All three will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	140	49	44	81	147	15	61	62
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

#	Indicator	Overall Score									
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.

Individual #61 and Individual #81 did have documentation of the training of SAPs in the community, however, there were no established goals for this activity. The remaining individuals did not have documentation of the implementation of SAPs in the community. 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.

Summary: Educational services need to be integrated into the ISP. This indicator, which met criteria at the last review, will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 34								
25	The student receives educational services that are integrated with the ISP.	0% 0/1	0/1								

Comments:
25. In order to score this indicator, the Monitoring Team chose Individual #34 to review. Individual #34 attended the local high school, however, none of his educational services were integrated into his current ISP.

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.

Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/5	0/1	0/1	N/A	0/1	0/1	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including	0%	0/1	0/1		0/1	0/1	0/1			

	timeframes for completion;	0/5									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/5	0/1	0/1		0/1	0/1	0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/5	0/1	0/1		0/1	0/1	0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/5	0/1	0/1		0/1	0/1	0/1			
	Comments: None.										

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.											
Summary: Overall, the Center did not have a way to measure individuals' progress in the area of communication. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	50% 2/4	N/A	0/1	N/A	1/1	0/1	N/A	1/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	25% 1/4		0/1		0/1	0/1		1/1		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/4		0/1		0/1	0/1		0/1		
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/4		0/1		0/1	0/1		0/1		
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/4		0/1		0/1	0/1		0/1		
	Comments: a. and b. Individual #15, Individual #27, Individual #46, and Individual #59 had functional communication skills, so goals/objectives were not indicated. Based on review of Individual #108's assessment, she did not have functional communication, but a goal/objective was not relevant. She resisted hand-over-hand assistance, and did not demonstrate interest in the use of AAC. The goal/objective that was clinically relevant, as well as measurable was Individual #48's goal/objective related to using a first/then schedule for vocational activities. The goal/objective that was clinically relevant, but not measurable was for Individual #19 (i.e., using communication device to indicate she needed to use the restroom).										

c. through e. For Individual #19, the only QIDP monthly summary submitted was for July 2016. It reported that no data sheet was submitted related to this goal, and that monthly reports for August, September, October, November, and December were pending. For Individual #48, the only monthly review submitted was for August and September, but it was completed in November 2016, and date stamped 1/19/17. As noted above, Individual #27, and Individual #46 had functional communication skills. They were part of the outcome group, so further review was not conducted. Individual #15, and Individual #59 were part of the core group, and so the Monitoring Team conducted full monitoring of their supports and services. Individual #108 did not have functional communication skills, so even though a goal/objective was not indicated, a full review was completed. For the remaining four individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or a lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	15	61	27	19	139	46	48	59	108
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	50% 1/2	N/A	N/A	N/R	1/1	N/A	N/R	0/1	N/A	N/A
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: a. For Individual #48's first/then SAP, for most of December 2016, no vocational class was held. However, it did not appear that provisions were made to implement the SAP in an alternative setting.											

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.											
Summary: The Center's performance on these indicators has varied. The Center is encouraged to continue to focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, and individuals use them functionally.			Individuals:								
#	Indicator	Overall Score	29	19							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 2/2	1/1	1/1							
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 1/2	1/1	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.	100% 2/2
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) to meet their appropriately identified needs, consistent with their informed choice.

This Domain contains five outcomes and 20 underlying indicators. At this time, none will be moved to the category requiring less oversight. With this round of reviews, the Monitoring Team just reinstituted monitoring of the Settlement Agreement requirements related to transition to the most integrated setting. In addition, earlier in 2016, the Center began additional post-move monitoring responsibilities, and had begun to follow individuals in the community for a year as opposed to 90 days.

The following summarizes some, but not all of the areas in which the Center has made progress as well as on which the Center should focus.

Seven individuals transitioned to the community since the last review and four were on the active referral list. Overall, there was much improvement in the transition work done by the APC, transition specialist/post move monitor, and IDT team members. The APC and TS were very receptive to feedback from the Monitoring Team, and if their progress since last review is a predictor of their progress from now until the next review, it is possible that many indicators will meet criteria. The Monitoring Team and the APC and TS spent a number of hours together reviewing the transitions of two individuals in much detail. In addition, a third individual was observed in the community during conduct of post move monitoring. Overall, the three individuals were doing well in their new homes. One of the individuals was someone the Monitoring Team had been following for a number of years.

More work was needed to make supports in the CLDPs measurable. In addition, a number of essential supports were missing from the CLDPs reviewed, and this should be a focus for Center staff. In particular, community provider training supports need to identify the staff to be trained, the specific competencies to be achieved, the methodologies required to achieve those competencies, and how staff competencies would be demonstrated, such as via role play or in vivo demonstration.

The Post Move Monitor conducted timely monitoring. Reports were completed, but more detail needed to be included regarding exactly what evidence was examined to determine if the support was being provided to the individual.

One individual had experienced a PDCT event. There was failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring. Fortunately, the event did not result in a failed transition. Her IDTs conducted a thorough post-event review.

There remained very poor transition assessments; and in some cases transition assessments were not submitted at all, prior to the CLDP meeting. These continue to need to identify supports that are necessary in community settings and how they might be provided specifically in the settings to which the individual will be moving, and working.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.											
Summary: Overall, Rio Grande SC made progress in improving the way supports were worded in term of measurability and in the comprehensiveness of the list of supports. Similar issues regarding details in the training of provider staff remained since the last review. Continued focus on the comprehensiveness of the list of supports is required. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	105	65							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments:
Seven individuals transitioned from the facility to the community since the last monitoring review (the same number as during the previous review period). Two were included in this review (Individual #105, Individual #65). Both individuals transitioned to a group home that was part of the State's Home and Community-based Services (HCS) program. Individual #65 was reported to be doing well overall. Individual #105 had experienced one potentially disruptive event, moving to a new home, but was reported to be adjusting well to this environment. The Monitoring Team reviewed these two transitions and discussed them in detail with the Rio Grande SC Admissions and Placement staff while onsite.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make adjustments as needed. Many, but not all, of the supports defined in the CLDPs for Individual #105 and Individual #65 were measurable. There was a need for better measurability wording in the area of pre-move training requirements, as described below. The Monitoring Team encouraged Rio Grande SC transition staff to continue to work with IDT members, particularly clinicians, to provide detailed recommendations in their discharge assessments, including specific and objective measures.

- The IDT developed seven pre-move supports and 38 post-move supports for Individual #105.
  - Three of the seven pre-move supports were for inservices to be provided prior to the transition. These provided no specific criteria to confirm competence of staff in any area, stating only that staff will receive training, and requiring only signature sheets as evidence. In some instances, such as for use of the shower chair and dining equipment or for diet texture, the IDT should have considered whether observation of staff engaging in specific activities should have been included as evidence.
  - Post move supports sometimes expanded upon the expectations for staff knowledge, such as providing the current diet. This was positive. On the other hand, post-move supports for the use of assistive equipment did not provide the needed detail that would set the expectations for the provider or allow the PMM to accurately evaluate whether the

support was in place.
    - Some post-move supports called for monitoring for changes, such as for Individual #105's weight, communication status, and swallowing abilities, but did not provide a baseline from which to assess whether changes had occurred or provide signs or symptoms staff should watch for that might indicate a change.
- For Individual #65, the IDT developed seven pre-move supports and 48 post-move supports.
    - Pre-move supports included provider staff to receive competency based training on many topics. Some did not provide detail that would indicate what staff should know and/or be able to do to provide his needed supports. Some, such as for adaptive equipment and current diet, did include a detailed list of items that should be included in the training and this was positive. Pre-move training supports stated the inservices would include provider train-the-trainer with a competency test at the end, but did not consistently provide specific criteria to confirm competence of staff. In some instances, such as for the use of adaptive equipment, competency confirmation might require demonstration by staff rather than a written quiz. For example, the related support indicated training should include the use of the hospital bed for proper positioning for resting and sleeping due to reflux precaution. A written competency quiz did test staff knowledge that the bed should be elevated to 30 degrees, but did not provide evidence that provider staff could accurately determine that elevation or how to achieve that elevation.
    - Some of the post-move supports for Individual #65 provided good specificity. These included behavioral supports and instructions for how to care for his partial dentures once they were received.
    - Many other post-move supports were overly broad and did not provide objective measures. For example, like Individual #105, Individual #65 also had post-move supports calling for the provider to monitor for changes in communication and swallowing changes that included no baseline or signs/symptoms that might indicate a change. Another post-move support stated the provider should refer to a dietitian or medical provider for any unplanned significant weight changes and/or nutritional status, but provided no indication of how to determine if a change was significant in nature based on his needs.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. While there was improvement, which was good to see, neither of these CLDPs met criterion overall, as described below. The total number of supports, however, was more than double what was in the Rio Grande SC CLDPs at the time of the last review. While the total number does not guarantee that the set of supports will be more comprehensive, it was good to see that the Center was thinking more broadly, including more supports, and including a wider variety of supports than at the time of the previous review.

- Past history, and recent and current behavioral and psychiatric problems:
    - Examples of past history, and recent and current behavioral and psychiatric problems that were not addressed for Individual #105 included the following:
        - Per the Integrated Risk Rating Form (IRRF) and the Individual Support Plan (ISP), the Positive Behavior Support Plan (PBSP) from 2014 needed to be updated.
        - Per the ISP, Individual #105 had sustained injuries over several years, many of which were the result of challenging behaviors of throwing herself to the floor and rolling. Per the IRRF, she was known to hit head at times when she drops to the floor. The CLDP did not include a support for intervention.
        - Per the IRRF, Individual #105 had challenging behaviors during mealtimes (yelling and crying with food in her

mouth and hyperextending neck), but the IDT provided no specific support for how to intervene or otherwise assist.
        - The CLDP included no supports related to staff knowledge of Individual #105's behavior of public disrobing or of her history of possible interest in sexual involvement with male peers. The IDT knew of these concerns and discussed that she should not live with male peers, but did not include this as a support. Instead, the IDT relied on the provider's statement that the male peer residing in the home would move prior to Individual #105's transition. This did not occur. If the IDT had developed a pre-move support, this would have prompted the PMM to take needed action at the time of the Pre-Move Site Review (PMSR).
    - For Individual #65, the CLDP included eight specific and detailed post-move supports describing behavioral strategies, including preventative actions as well as interventions for target behaviors. This was positive, providing clear expectations for both provider staff and the PMM. Examples of past history, and recent and current behavioral and psychiatric problems that were not as carefully addressed included the following:
        - The CLDP profile indicated Individual #65 would need a routine level of supervision once he became used to his new living environment. The profile went on to note he would attempt to consume excessive amounts of fluids at a fast pace, obtain food items outside of his recommended diet, and had been known to expose his genitals in public. The CLDP narrative did not make clear how routine supervision would address these needs, nor did it include a specific supervision support, in any event.
        - Individual #65 also had a significant history of alcohol and drug use that had resulted in arrest and imprisonment. Per the medical assessment, this dependence was in institutional remission, indicating that he lacked access to drugs and alcohol in the very controlled environment of the Center. The CLDP did not include supports for staff knowledge of this history or how this might impact his need for supervision in a community setting that might provide increased access.
        - The PBSP was not current. The last update reported was August 2015.
- Safety, medical, healthcare, therapeutic, risk, and supervision needs: For both individuals, the respective IDTs identified many supports for various follow-up appointments and consultations, which was positive. Otherwise, there were a number of concerns identified by the Monitoring Team in the areas of safety, medical, healthcare, therapeutic, risk, and supervision needs, including the following:
    - For Individual #105:
        - Individual #105 had a service objective (SO) to swab her gums for oral care, but the CLDP did not specifically address oral care. It only indicated that staff would assist with all activities of daily living (ADLs).
        - The ISP indicated an occupational therapy (OT) assessment of ADLs was needed, but this had not been completed. The CLDP did not include a support for this need.
        - The ISP noted the optometrist indicated Individual #105 needed cataract surgery and was scheduled to be re-evaluated by the ophthalmologist. No vision was assessment provided, but her medical update indicated a consultation on 3/3/16, with follow-up in one year recommended, was included in supports.
        - The IRRF noted the IDT did not know why Individual #105 frequently screamed out while eating, yet the CLDP provided no evidence the IDT had thoroughly assessed what the etiology might have been or recommended any support for further evaluation. The IDT needed to ensure this was not related to discomfort or a physical issue.

- The CLDP did not include specific supports for dining strategies, only stating to continue with assistive equipment as per the physical and nutritional management plan (PNMP). The pre-move training support in this area was broad with no specific competencies that addressed staff knowledge. Staff knowledge should have included to prompt her to scoop small amounts of food at a time, to pour a small amount (enough for a swallow) of fluid in a nosey cup, for staff to place a hand behind her neck to keep her from hyperextending, and to swallow two times when she is done eating with liquids. The training competency tests did not address these.
- Individual #105 had a recently resolved history of GERD, requiring supports. The CLDP did not include a support for staff knowledge signs/symptoms to watch for in the event of a recurrence.
- Per the IRRF, Individual #105 had experienced gradual weight loss and a reduction in her body mass index (BMI) over time, as well as a history of meal refusals. At the time of the ISP, the IDT raised her risk rating to medium and agreed she needed to be monitored for further weight loss. The CLDP did not include a support to monitor for weight loss or further reduction in BMI, or for any action to be taken in the event either occurred. It included only a support to have body weight scales to obtain a baseline weight within two days and to obtain and monitor weights for good health.
- Per the IRRF, Individual #105 had frequent falls, estimated at 24 between January 2015 and January 2016. The causes included tripping over objects, peer to peer aggression, letting herself fall to the ground, and a need for routine follow-up with a podiatrist to debride calluses on her feet. The CLDP did not include an overall support for staff knowledge of her falls risk. Supports did not include some important related strategies, including to have staff let her hold their arms and frequent podiatry follow-up for debridement of calluses. It also did not include a support with specific strategies for prevention of letting herself fall to the ground.

- For Individual #65:
  - The CLDP included a pre-move support for providing medication as prescribed, to include reporting to clinicians when side effects/symptoms were observed. The IDT did not develop supports that provided any detail as to what the side effects might be.
  - Individual #65 had been fitted for partial dentures that had not been delivered as of the time of the CLDP. The IDT included detailed supports about how the partials should be cared for, which was positive. The IDT should also have developed a support to ensure delivery, but did not. As of the time of the 45 day PMM visit, the dentures had not yet been delivered. Per interview with transition staff at the time of the monitoring visit, the dentures had yet to received.
  - The CLDP did not include specific provider staff training with competency criteria regarding his diagnosis of diabetes insipidus. Instead, it provided a disjointed set of post-move supports that were often couched as recommendations that did not make clear how critical they were in relation to his diagnosis.
  - The CLDP included no pre-move training supports for other specific medical diagnoses, including his high risk for GI complications due to diagnoses and history of reflux esophagitis, gastritis, diaphragmatic hernia, Barrett's esophagus, and constipation.
  - Individual #65 had a recent (2016) history of blood in his stool, but the CLDP included no support for staff knowledge or monitoring related to recurrence.
  - Individual #65 was at medium risk for cardiac disease. The IHCP called for twice-monthly vital signs, but the

    - IDT did not include this in any support or prescribe any nursing monitoring.
    - Per the IRRF, side effects monitoring should occur every six months, but the CLDP did not include a support in this regard.
- What was important to the individual was captured in the list of pre-/post-move supports.
  - The CLDP narrative stated outcomes important to Individual #105 included participating in outings, spending time outdoors, having her nails painted, listening to music and flipping through magazines. ISP personal goals and action plans included learning to operate her radio, go on shopping trips, and get manicures. Another called for her to go to a local salon with a group of peers to help develop friendships. The CLDP did not address manicures, shopping trips, or developing friendships.
  - Individual #105's guardianship had expired. The CLDP did not include a support or consideration of her need for a guardian in the community setting.
  - Individual #105 wanted to live closer to sister, but the CLDP did not specify any support for encouraging or maintaining contact.
  - The CLDP for Individual #65 met criterion for this sub-indicator. The CLDP narrative indicated the outcome important to Individual #65 was to successfully transition to community. CLDP also included supports for spending time with family and talking to them on the phone, as well as the opportunity to apply at Pep Boys, where he wanted to work. Other supports called for him to have access to specific preferred items and activities.
- Need/desire for employment, and/or other meaningful day activities:
  - For Individual #105, the only supports described in this area were to attend the day program Monday through Friday and for the daily schedule to be consistent at the home and day program. The CLDP did not include any supports related to other meaningful day activities in integrated community settings; in fact, it did not include any supports related to community activities. The vocational assessment noted that learning exercises created around clothing would be beneficial, but this was not included. It was concerning the vocational assessment indicated the trainer had no recommendations related to various training objectives, such as academics, physical fitness, sensory, arts and crafts, money management, and community outings. The vocational assessment indicated she attended only in the afternoons with constant refusals to stay in class, engaged in frequent targeting of peers, and frequent sleeping in class. The IDT did not address any of these barriers with related supports.
  - For Individual #65, the CLDP did not thoroughly address supports needed to achieve his desired employment outcomes. His personal goal was to work as a mechanic and he wanted to apply at Pep Boys. The IDT developed a support stating he would have the opportunity to apply at Pep Boys, with a timeline beginning December 12, and daily thereafter. The IDT did not consider other supports he might need, such as assistance with obtaining and completing applications or a DARS referral. Supports should have addressed the desired outcome of having paid work, rather than being limited to an opportunity to fill out an application.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Both CLDPs addressed positive reinforcement, incentives, and other motivating components and met criterion for this sub-indicator.
  - For Individual #105, the CLDP included several specific supports about providing her with reinforcement as well as environmental and schedule design.
  - The CLDP for Individual #65 included supports that described how staff should interact with him, such as talking with him throughout the day, making eye contact, and saying something positive about his work, appearance, or attitude.

Supports further included providing preferred activities and praise for completing scheduled tasks. Behavioral strategies also described positive approaches for assisting him to make good decisions about his diet restrictions.

- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed no pre or post-move supports for either individual for the teaching, maintenance, participation, and acquisition of specific skills based upon their needs and preferences, such as in the areas of personal hygiene, domestic, community, communication, and social skills. It was concerning that a Functional Skills Assessment (FSA) update had not been completed for either of these CLDPs, despite transition staff having requested these.
- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, the Center implemented a good process for reviewing CLDP assessments and making and documenting team decisions about recommendations. Still, there were recommendations that were either not addressed or did not have an adequate rationale provided for not being included. The Monitoring Team found it particularly troubling that key recommendations from the QIDP and Registered Nurse Case Manager (RNCM) were not available for discussion at the time of the CLDP and had to be added later.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.

Summary: The Center continued to provide post move monitoring, though as indicated in the detail below, improvements in actions and in documentation are required in order to meet criteria with these indicators. This is especially true for the important supports of community provider staff training and their expected resultant knowledge and competencies. Observation of post move monitoring indicated it was being done thoroughly and suggestions for improvement from the Monitoring Team were implemented immediately regarding details in the report. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	105	65							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	0% 0/2	0/1	0/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	0% 0/2	0/1	0/1							
6	The PMM's scoring is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the	0%	0/1	0/1							

	CLDP, the IDT/Facility implemented corrective actions in a timely manner.	0/2									
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	100% 1/1	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	100% 1/1	N/A	N/A							

Comments:

3. Post-move monitoring was completed for four PMM periods for Individual #105 and for two periods for Individual #65. These were timely and included observations at all locations. PMM reports were done in the proper format. They generally included comments regarding the provision of every support, but some were not thorough enough in addressing the respective supports.

- For Individual #105, the narrative summary in the Transition Specialist's log was helpful in providing additional information beyond the PMM Checklist. Still, the documentation overall did not consistently provide details that addressed all of the required evidence. For example, the PMM did not routinely reference the review of the support checklists as indicated in the column specifying the evidence required.
- For Individual #65, a pre-move support called for provider staff to be inserviced on quality of life preferences, specifically including the opportunity to listen to music of his preference and to be given a choice to go to a football game. The PMM only referenced staff knowledge of playing music.

4. Reliable and valid data that report/summarize the status regarding the individual's receipt of supports: In many cases, the PMM Checklists provided reliable and valid data that reported/summarized the status regarding receipt of supports, but this was not the case for all supports. For both individuals, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports as described in indicator 1. For example, both individuals had supports to be referred for MBSS and SLP supervision if there was a change in feeding and swallowing abilities. The PMM documented there had been no changes, but there were no criteria or signs/symptoms upon which to base these determinations. The IDT members needed to be cautious about providing recommendations in their assessments that were not clearly individualized to each person's needs.

- For Individual #105, other examples included:
  - The PMM documented staff assisted with ADLs, but did not address assistance with oral care.
  - The PMM documentation did not make clear whether Individual #105 was provided with a daily schedule that was consistent at home and day programming for three of the four monitoring periods. It only addressed this consistency at the time of the 180 day.
  - Comments for supports describing what to do when she has been yelling and crying did not address the specific staff knowledge of these strategies.
  - A support called for staff to provide the dining supports listed in her PNMP. The data collected by the PMM did not provide any evidence staff were knowledgeable of the dining instructions.
- For Individual #65:
  - The CLDP included a support to continue on his current diet. Specific requirements included his diet texture and

various others, such as filling the Provale cup up to fill line and using during mealtimes and snacks only, offering Boost Plus if he consumes 50% or less and providing Boost with each meal, providing Benecalorie with hot foods and Boost vanilla pudding at lunch, and a low fat snack three times a day. The PMM addressed only the diet texture at the seven day PMM visit and only the diet texture and the use of cup at the 45 day PMM visit. She did not document testing staff knowledge of these specific requirements.

- The CLDP included a support for monitoring of his weight on a monthly basis. The January 2016 weight was not available, but the support was marked as present.
- The PMM documented she did a visual check of the requirement that the head of Individual #65's bed be elevated at a 30% incline. It was not clear if the visual check was based on objective evidence such as a mechanism indicating the elevation or was purely subjective on the part of the PMM.

5. Based on information the PMM collected, these individuals were not consistently receiving the supports described or listed in the CLDP without sufficient justification. As described in Indicator #4 above, reliable and valid data were not consistently available to ascertain whether supports were in place as needed.

- For Individual #105, the PMM indicated many supports were being received as required, but there remained instances in which they were not, but should have been. Examples included:
  - At the time of this monitoring visit, Individual #105 had not yet received a well woman exam, due in November 2016. An attempt had been made in a timely manner, but she had been uncooperative. The provider had not yet scheduled another appointment.
  - The process for the provider becoming representative payee had been delayed well past the August 2016 due date and was not entirely resolved at the time of the 180 day PMM visit that took place in January 2017. Per interview with the transition staff, this had recently been completed.
  - The PMM documented that Individual #105 continued to use a list of adaptive equipment, but provided no detail as to staff knowledge of these items, such as how they were using the communication poster board.
- For Individual #65, other examples of supports not being received as required included:
  - Documentation indicated the opportunity to apply at Pep Boys was pending at the seven and 45 day PMM visits. At the time of the monitoring visit, the support had not yet been implemented.
  - At the time of the 45 day PMM visit, Individual #65 was not using coated youth spoon.

6. In many cases, PMM's scoring appeared to be correct, but this was not always the case. In some, the PMM's efforts to score correctly were compromised by the lack of defined objective measures and/or the lack of reliable and valid data. Other examples of scoring that were not correct included:

- For Individual #105:
  - The process for the provider becoming representative payee was delayed and not entirely resolved at the time of the 180 day PMM visit, as the Center continued to receive some of Individual #105's funds. The PMM noted additional action needed but the PMM Checklist indicated the support was in place at that time.
  - Individual #105 moved to another home on 10/11/16. The 90 day PMM Checklist documented there had been new staff who would require training per the pre-move support. Per interview, all staff in the new home had been trained at the original training. Given that training had occurred almost three months earlier, the PMM needed to carefully test

and document staff knowledge.

- For Individual #65:
  - At the seven day PMM visit, the medication administration record was not available to document treatment, but the PMM Checklist indicated the support was present.
  - At the 45 day PMM visit, he was not using the coated youth spoon, but the related support was marked as in place.
  - Also at the 45 day PMM visit, Individual #65 had not been seen for denture follow-up, but the support was marked as not applicable, instead of not in place.

7-8. The Center's protocol for review of the PMM Checklists included sending the completed documents to the QIDP for review after each scheduled visit. If the PMM identified a concern, she requested a meeting of the IDT. The Center still needed improvement in consistent implementation of corrective actions in a timely manner. Examples included:

- Individual #105's well woman exam had not yet been completed, as described above. In interview, the PMM reported planning to follow-up at the next PMM monitoring period, which would be up to six months later.
- For Individual #65, the Behavior Analyst (BA) needed to complete an additional training requested by the provider on 2/2/17. The BA had not yet completed the training and no follow-up had been completed. The PMM indicated planning to take follow-up action for the incomplete support for application at Pep Boys at the time of the next monitoring visit, but more timely action was needed.

9-10. The Monitoring Team reviewed the conduct of the nine-month (255 day) post move monitoring for Individual #133. Post move monitoring and the post move monitoring report were done for her day program and for her home. The Monitoring Team observed at the day program and reviewed the completed report for both locations. Post move monitoring was conducted thoroughly and all relevant supports were explored at the day program.

The Monitoring Team provided suggestions after the observation for the PMM to include more specificity in her report about exactly what evidence she examined to determine if the support was being provided (i.e., the three prongs of post move monitoring: documentation, interview, and observation) as well as to indicate in the PMM report the difference between what the CLDP called for and what she actually did. Usually, the PMM examined more evidence than what was stated in the CLDP. In the report that was submitted to the Monitoring Team in the weeks following the observation, these changes (improvements) were made and were evident.

The Monitoring Team also suggested that staff interviews include those staff who provide daily direct supports and that the PMM could ask the supervisor if she could conduct a short interview without disrupting supervision or activities. Usually, supervisors in these situations are more than willing to make this happen, that is, to supervise the individuals themselves or make arrangements for other staff to provide supervision.

During the observation, Individual #133 was very verbal, engaging, and made positive comments about her home and day program.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.	
Summary: One individual had no negative events occur. The other had negative events that occurred after her transition and, fortunately, did not result in a return	Individuals:

to the facility. A review of the incidents, the CLDP, and the transition assessments showed that some supports were missing from the CLDP that would have reduced the likelihood of these incidents having occurred. Even so, the facility did a good review of this incident. This indicator will remain in active monitoring.										
#	**Indicator**	**Overall Score**	**105**	**65**						
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1						

11. Individual #65 had not experienced any negative PDCT events as of the time of the monitoring visit. Individual #105 had moved to a new home, as described below.
    - On 10/11/16, Individual #105 moved to a different home after going to the room of a male roommate and removing her clothing. She had a history of inappropriate sexual behavior, but the IDT acknowledged at the time of the ISPA that provider staff may not have been trained on this issue because it had not occurred at the Center within the last year prior to transition. This illustrated the importance of including in provider training a thorough history of behavioral needs. The IDT further noted it had recommended an all-female home, but had been told the sole male occupant in the prospective home was going to be moving before Individual #105 transitioned. The IDT did not develop a specific support for an all-female home. The PMM did not document this as an issue requiring resolution at the time of the PMSR, even though the male roommate was still in residence.
    - The IDT completed a thoughtful analysis of the circumstances of this PDCT, including some things that could have been done differently, such as the completion of a more detailed residential assessment by a staff more familiar with Individual #105's needs. The IDT also identified that it should have specifically stipulated that no male peers live in the home. The IDT did not specify the lack of training on her inappropriate sexual behaviors as one of the things that could have been done differently, but did note this in the description of the event.
    - Overall, it was positive to see the IDT completing a critical analysis of the PDCT.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.	
Summary: This outcome focuses upon a variety of transition activities. Rio Grande SC made progress on some of these indicators, though as detailed below, improvements in quality and detail are needed. The completion of all relevant assessments as well as the quality of transition assessments are areas of focus for the Center. Although Center staff provided training to community provider staff, the CLDPs did not define the training well, especially regarding staff competency. The	Individuals:

transition activities in indicators 15-18 were occurring (and were documented) for some individuals. The indicators of this outcome will remain in active monitoring.

#	Indicator	Overall Score	105	65							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	50% 1/2	0/1	1/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	50% 1/2	0/1	1/1							
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	100% 2/2	1/1	1/1							
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:

12. Assessments, for the most part, did not meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance. The Monitoring Team was particularly concerned that some IDT members did not provide discharge assessments that were timely, available for the CLDP meeting or represented individuals' current needs.

- Updated within 45 Days of transition: The Center did not review or update the Integrated Risk Rating Form (IRRF) for either of

the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. The Admissions Placement Coordinator (APC) should ensure that the IDTs review the status of the IRRF as part of the transition assessment process.

- For Individual #105, the IDT did not ensure completion of the following discharge assessments: psychiatry, FSA, audiology, and vision. The behavioral health assessment and PBSP were outdated.
- For Individual #65, the IDT did not obtain updated did not provide psychiatry, FSA, audiology, or vision assessments. The residential and pharmacy assessments were undated. The CLDP also indicated that the QIDP and nurse did not provide updated recommendations until after the CLDP meeting, even though these were all requested.
    - The Center should re-evaluate its protocol and policy for ensuring disciplines are responsive to the requirement for updated discharge assessments.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments that were not available or updated had a negative impact on the scoring of this indicator for both individuals.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that were not available or updated continued to have a negative impact on the scoring of this indicator for both individuals.
    - For Individual #105, examples of other assessments that did not provide a comprehensive set of recommendations that would be adequate for planning or focus on the new settings included:
        - At the ISP, the physical therapist recommended an OT assessment to assess Individual #105's ADL skill to determine her current status. An OT had not completed such an assessment and, per the signatures, did not participate in the assessment provided by Habilitation Therapies.
        - The SLP stated provider staff would need suggestions on how to interact with Individual #105 if not familiar with her, but did not offer any specific recommendations. The Monitoring Team was also concerned that the SLP assessment included a recommendation that Individual #105 may need an evaluation if significant changes in communication abilities, without providing any baseline or indications for what might represent a significant change.
    - For Individual #65:
        - The SLP assessment included the same recommendation as described above for Individual #105, without any individualization.
        - The dental assessment provided no recommendations about the dentures Individual #65 was about to receive.
        - The vocational assessment stated Individual #65 would need an in-depth vocational assessment, and that more assessments were needed to explore work preferences. It was concerning these assessments had not been completed while Individual #65 was living at the Center.
- Assessments specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting: Assessments did not consistently meet criterion for this indicator. Again, the many missing and late assessments factored into this determination.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator.

- IDT members actively participated in the transition planning process. There was documentation to show IDT members actively

participated in the transition planning process. Both CLDPs met criterion in this regard.

- The CLDP specified the SSLC staff responsible for transition activities, and the timeframes in which such actions are to be completed: Both CLDPs met criterion for this sub-indicator.
- The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting: Criterion was met for this sub-indicator for both individuals.

14. Documentation did not indicate Center staff provided training of community provider staff that met the needs of these two individual, including identification of the staff to be trained and method of training required. Training did not consistently define the training methodology or competency criteria for key supports or include any competency testing or demonstration, as described in detail in indicators 1 and 2. In addition, the behavioral health training for Individual #105 was based on an outdated 2014 PBSP, which the IDT had indicated needed to be updated. For Individual #65, the competency quiz for the PBSP was comprised of only five questions, despite the many behavioral supports in the CLDP and the complexity of his PBSP. The Monitoring Team could not discern if the quiz had been updated to be pertinent to the new setting. For example, one of the five questions asked what teaching strategy should be documented in the ME book. There was no evidence the provider used a ME book, which was a facility practice.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDP should provide a specific statement documenting its consideration of the need for any such collaboration. Neither of these CLDPs met criterion for different reasons. Individual #105's CLDP did not include any evidence her IDT had considered whether such a need existed. Individual #65' CLDP was more recent and reflected an improved process in that it specifically documented the IDT's consideration. This was a positive development. In this case, the IDT agreed the Center's psychiatrist should communicate with the community psychiatrist, once one was identified, to recommend no changes in medications for first six months. It was positive the IDT documented its consideration of the need for this collaboration, but it did not include a support to ensure this was completed. No evidence indicated the collaboration had occurred.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: Individual #105's IDT did not document a statement regarding the need for any setting assessment and did not meet criterion. The CLDP for Individual #65 did meet criterion. It provided a specific statement as to the IDT's consideration of whether any assessments of setting were needed.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. The CLDP for Individual #105 did not address any of these examples, but the CLDP for Individual #65 did document the IDT's deliberation.

18. Both CLDP's met criterion for collaboration between SSLC staff and LIDDA staff. The Transition Specialist's logs provided a good description of this collaboration.

19. Neither of these CLDPs met criterion for pre-move supports being in place in the community settings on the day of the move. For both individuals, it was concerning that pre-move supports did not require evidence of staff knowledge and competence. It is

incumbent upon the Center to ensure staff competence to provide supports essential to health and safety prior to the move, rather than waiting seven days until the first PMM visit. The initial seven days after transition is a critical period, during which a lack of staff knowledge can lead to negative outcomes. For Individual #65, the PMSR did not provide any comments at all describing the evidence the PMM relied upon to determine if supports were in place. Instead, only the checkboxes were completed.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: The transitions for both individuals occurred in a timely manner. This indicator will remain in active monitoring. With sustained high performance, it might move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	105	65							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1							
Comments:											

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 or 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 and/or 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 <u>and</u> 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