United States v. State of Texas

Monitoring Team Report

Rio Grande State Center

Dates of Onsite Review: November 27-November 30, 2017

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Submitted By:	Alan Harchik, Ph.D., BCBA-D Maria Laurence, MPA Independent Monitors
Monitoring Team:	Helen Badie, M.D., M.P.H, M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Victoria Lund, Ph.D., MSN, ARNP, BC Gary Pace, Ph.D., BCBA-D Scott Umbreit, M.S. Rebecca Wright, MSW

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
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. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

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. At the last review, one of these indicators was moved to the category of requiring less oversight. No additional indicators were moved this category during this review.

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.

Restraint

Overall use of crisis intervention restraint at Rio Grande SC showed a decreasing trend, especially when compared with the increasing trend seen over the previous three nine-month periods. This was likely due to increased attention to the use of restraint at the Center, such as increased staff training, in vivo observation by behavioral health services staff, video review of every restraint and behavioral episode, and various meetings and discussions. Also, the use of crisis intervention chemical restraint also decreased markedly, from 48% of crisis intervention restraints to 17% of crisis intervention restraints.

Through the course of these restraint-reduction activities, the Center found that some crisis intervention physical restraints were not recorded or reported (i.e., discovered restraints). The Center took actions to reduce the likelihood of future occurrences. Some of the restraints chosen for review by the Monitoring Team were, coincidentally, discovered restraints. Due to this, various documentation requirements of the outcome and its indicators regarding restraint were, for the most part, not met.

The Monitoring Team's review of the three restraint episodes identified significant issues with reporting, nursing assessment, documentation, and auditing. During the onsite review, the Quality Assurance (QA) Director indicated that she was auditing the nursing section of the restraint process and recognized that she was not auditing for the quality of the documentation or the

clinical appropriateness of the nursing assessments. Given that nurses play a critical role in ensuring individuals' safety during and after the restraint process, the Monitoring Team recommends that a nurse who is clinically competent be assigned to review nursing's role in restraints.

Abuse, Neglect, and Incident Management
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.

At the SA-PIC QAQI Council meeting during the onsite week, the Center showed that it was taking some serious steps to complete a number of long-outstanding corrective action plans for individuals. This was good to see.

Other
Regarding pretreatment sedation, IDTs commented that desensitization had failed in the past and, therefore, no treatment strategies were warranted. The Monitoring Team suggests that other treatment strategies, perhaps other than formal desensitization, might be trialed for one or more of these individuals in the future.

Center staff had not identified and/or reported adverse drug reactions (ADRs) for any of the individuals reviewed. However, in reviewing documents the Center submitted, the Monitoring Team identified potential ADRs for two individuals. It is essential that the Center have a system to ensure that potential ADRs are reported immediately, further investigated, and probability scales completed.

It was good to see that the Center completed two clinically significant Drug Utilization Evaluations (DUEs), which was an improvement from the last two reviews. However, the minutes the Center submitted did not clearly identify any deficiencies the DUEs uncovered, and/or plans to correct the problems noted.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: Overall use of crisis intervention restraint at Rio Grande SC showed a decreasing trend, especially when compared with the increasing trend seen over the previous three nine-month periods. This was likely due to increased attention to the use of restraint at the Center, such as increased staff training, in vivo observation by behavioral health services staff, video review of every restraint and behavioral episode, and various meetings and discussions. Through the course of these activities, the Center found that some crisis intervention physical restraints were not recorded or reported (i.e., discovered restraints). The Center took actions	Individuals:

to reduce the likelihood of future occurrences. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (February 2017 through October 2017) were reviewed. The overall use of crisis intervention restraint at Rio Grande SC decreased since the last review, and an increasing trend that was observed over the past three nine-month periods was reversed. When looking at the census-adjusted trend in overall use of crisis intervention restraint, a decreasing line was seen through the first seven months, with an increase in the eighth month. This was due to a series of restraints during the first two days of a new admission (Individual #53). After those two days in early September 2017, no crisis intervention restraints were implemented with her again. The rate of crisis intervention physical restraint paralleled the overall use of crisis intervention restraint because most crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint was about four minutes, which was about in the middle compared with the other Centers.

The use of crisis intervention chemical restraint also decreased markedly since the last review. At the last review, there was an increasing trend in crisis intervention restraint and 48% of those were crisis intervention chemical restraints. During this review, there was a decreasing trend in the use of crisis intervention restraint and 17% of those were crisis intervention chemical restraints.

There were no instances of the use of crisis intervention mechanical restraint or protective mechanical restraint for self-injurious behavior (PMR-SIB). There were no instances of protective devices being improperly utilized as restraint. There was one report of injury during restraint, but it was a non-serious scratch. That being said, nursing examination of individuals for injury post-restraint was not occurring properly and/or was not being documented properly, so these data may not be accurate. The number of individuals who had a crisis intervention restraint per month, however, showed an increase in the last two months of the review period; those two months each had more individuals than any of the other months in the review period.

There was a decreasing trend in the use of non-chemical restraints for medical procedures to zero occurrences in the last five months, and zero occurrences of the use of non-chemical restraints for dental procedures during the entire review period. The use of pretreatment sedation for medical and dental procedures also showed decreasing or low rates of usage. The use of TIVA showed a slightly increasing trend.

Thus, facility data showed low/zero usage and/or decreases in 10 of these 12 facility-wide measures (i.e., overall use of crisis intervention restraint; use of crisis intervention physical, chemical, and mechanical restraint; duration of crisis intervention physical restraint; use of protective mechanical restraint for self-injurious behavior; injuries during restraint; use of non-chemical restraints for

medical/dental procedures; and use of pretreatment sedation for medical/dental procedures). This compared with six of 12 at the last review.

Discovered restraints: Of concern, however, was that a number of crisis intervention restraints were not reported by staff after their occurrence. This was the case for the crisis intervention restraints chosen by the Monitoring Team for review and described in the remainder of this section of the report. This phenomenon, which has come to be called "discovered restraints," was itself discovered by the Center a number of months ago. The Center took immediate actions to address it and to reduce the likelihood of further occurrences. The Monitoring Team met with the Center's director of behavioral health services and director of quality management a number of times during the onsite week. In addition, they prepared a packet of information showing various emails, meeting minutes, notes of video reviews conducted by behavioral health services staff, minutes of ISPA restraint review meetings, IMRT notes, CAP logs, and restraint reduction committee agenda and minutes.

It appears to the Monitoring Team that decreases in restraint usage occurred, at least in part, as a result of the Center's responsiveness to the Monitoring Team's findings last time. That is, when there was an increasing restraint frequency. To that end, behavioral health services and quality management initiated many activities, such as numerous staff trainings, increased direct in vivo observations, video review of restraints and behavioral incidents, pocket cards for all staff about restraints, and improvements to the restraint reduction committee. At the same time, however, and due, at least in part, to increased direct observation and video reviews, some restraints were discovered that had occurred without being reported or documented properly (i.e., discovered restraints).

The Monitoring Team does not believe that there was any intentional under-reporting. Each of the four occurrences had some rationale, such as there having been multiple consecutive restraints, not all of which were recorded; a staff member holding an individual's arm during an aggressive episode for 20 seconds and failing to consider that to have been a physical restraint; and some miscommunication between staff as to whom was reporting and recording a restraint. These kinds of errors are rarely seen at most SSLCs at this point, so increased scrutiny, training, and monitoring was an appropriate response by the Center. The Center is now tracking (trending and graphing) occurrences of discovered restraint, too.

2. Three of the individuals reviewed by the Monitoring Team were subject to restraint. Of these, two received crisis intervention physical restraints (Individual #51, Individual #50) and one received crisis intervention chemical restraint (Individual #53). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for all three (Individual #51, Individual #50, Individual #53).

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: These restraints were reported late or were discovered to have occurred by the Center without being reported. As described in detail above in outcome 1, the Center took action to reduce future likelihood of this occurring. However, the many requirements of this outcome and its indicators did not, as a result, meet criteria. They will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	51	50	53						
3	There was no evidence of prone restraint used.	100% 3/3	1/1	1/1	1/1						
4	The restraint was a method approved in facility policy.	67% 2/3	1/1	0/1	1/1						
5	The individual posed an immediate and serious risk of harm to him/herself or others.	33% 1/3	1/1	0/1	0/1						
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	33% 1/3	1/1	0/1	0/1						
7	There was no injury to the individual as a result of implementation of the restraint.	33% 1/3	1/1	0/1	0/1						
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	0% 0/3	0/1	0/1	0/1						
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/3	0/1	0/1	0/1						
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	0% 0/3	0/1	0/1	0/1						
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	0% 0/3	0/1	0/1	0/1						

Comments:
The Monitoring Team chose to review three restraint incidents that occurred for three different individuals (Individual #51, Individual #50, Individual #53). Of these, two were crisis intervention physical restraints and one was a crisis intervention 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.

3-11. These restraints were discovered after their occurrence. The occurrence of discovered restraints is described in detail in outcome 1 above. Due to this, the various documentation requirements of this outcome and its indicators were, for the most part, not met.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: See comments below.			Individuals:								
#	Indicator	Overall Score									
12	Staff who are responsible for providing restraint were	Due to the Center's sustained performance, this indicator was moved to the									

	knowledgeable regarding approved restraint practices by answering a set of questions.	category of requiring less oversight.

Comments:
12. Due to the problems in reporting restraints, the Monitoring Team interviewed nine PNA staff individually, about restraint practices and requirements. They were from the two homes and the day program, from different shifts, and various tenures of employment. Five reported that they had never implemented a crisis intervention restraint. All were knowledgeable about methods to avoid restraint and to de-escalate situations. They were also knowledgeable about the need to report any restraint occurrence. Four did not report prone restraint (face-down) as being prohibited, but acknowledged that it was prohibited once the Monitoring Team stated it.

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: Face-to-face assessments by a restraint monitor were not conducted. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	51	50	53						
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	0% 0/3	0/1	0/1	0/1						
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A						

Comments:
13. Face-to-face assessments by a restraint monitor were not conducted.

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: The Monitoring Team's review of the three restraint episodes identified significant issues with reporting, nursing assessment, documentation, and auditing. During the onsite review, the QA Director indicated that she was auditing the nursing section of the restraint process and recognized that she was not auditing for the quality of the documentation or the clinical appropriateness of the nursing assessments. Given that nurses play a critical role in ensuring individuals' safety during and after the restraint process, the Monitoring Team recommends that a nurse who is clinically competent be assigned to review nursing's role in restraints. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall	51	50	53						

		Score									
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/3	0/1	0/1	0/1						
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	0% 0/3	0/1	0/1	0/1						
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/3	0/1	0/1	0/1						

Comments: The crisis intervention restraints reviewed included those for: Individual #51 on 9/15/17 at 4:12 p.m., Individual #50 on 7/26/17 at 5:45 p.m., and Individual #53 on 9/11/17 at 7:00 p.m. (chemical and physical).

a. through c. For Individual #51, the Center did not provide an IPN, PCP order, nursing assessments, or vital signs. Rather, the Center indicated in response to each of these requests that they were "not applicable as there is no physician order for restraint due to restraint being identified late," "not applicable due to restraint being identified late" for IPN, "not applicable" for any related nursing flow/data sheet, and "not applicable as no injuries were reported related to the restraint" regarding injuries. Additional documentation (i.e., TX-RG-1711-I.50h) noted that "Restraint identified during video review for IOAs [inter-observer agreement activities]." The documentation on the Debriefing form indicated "NAs" for "Nurse Checked" injury, vital signs, mental status, and physician order obtained. In addition, "Restraint Checklist completed correctly" was scored a "yes." There was no indication on the Restraint Checklist or Debriefing form that the restraint was identified as a result of video review, and apparently, that staff involved in the restraint had not made the appropriate notifications.

For Individual #50's restraint, the Center's response to the document requests was "not available."

On 9/11/17 at 6:45 p.m., Individual #53 was administered Haldol 10 milligrams (mg) and Benadryl 50 mg intramuscular (IM), and, according to the Medication Administration Records (MARs) provided, at 5:03 p.m., she was administered Ativan 2 mg IM, but the nursing IPN indicated the third IM was given at 7:03 p.m. PCP orders indicated that the Ativan 2 mg IM was ordered at 7:01 p.m. Nursing IPNs did not clearly indicate why a second chemical restraint was needed less than 20 minutes after the first chemical restraint was administered. In addition, the IPN did not indicate if the individual had to be physically restrained for each of the chemical restraint's administered. On 9/11/17, nursing staff monitored vital signs until 10 p.m. However, given that Individual #53 had received three IM medications within 17 minutes, nursing staff should have monitored her for an extended period of time and conducted mental status exams. The next day, nursing staff also should have conducted follow-up assessments to determine whether or not the individual was over-sedated, and/or able to attend scheduled activities, as well as to determine her mental status. No nursing documentation was found addressing assessment for injuries. The Post Chemical Restraint Clinical Review form provided noted "N/As" for both the Pharmacist and Psychiatrist reviews. Although not scored, no Restraint Checklists or Debriefing Forms were provided for physical restraints at 6:40 p.m. and 7:00 p.m. prior to the chemical restraints. The Center's response to the requests for these documents indicated that they were "Not available."

The Monitoring Team's review of the three restraint episodes identified significant issues with reporting, nursing assessment, documentation, and auditing. During the onsite review, the QA Director indicated that she was auditing the nursing section of the

restraint process and recognized that she was not auditing for the quality of the documentation (i.e., but rather, just the presence of documentation) or the clinical appropriateness of the nursing assessments. Given that nurses play a critical role in ensuring individuals' safety during and after the restraint process, the Monitoring Team recommends that a nurse who is clinically competent be assigned to review nursing's role in restraints.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Restraints were not documented properly due to their being discovered at a later time. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	51	50	53							
15	Restraint was documented in compliance with Appendix A.	0% 0/3	0/1	0/1	0/1							
Comments: 15. Restraints were not fully documented properly.												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Restraints were being reviewed at Rio Grande SC, however, these restraints were discovered late and typical reviews were not conducted. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	51	50	53							
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	0% 0/3	0/1	0/1	0/1							
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/3	0/1	0/1	0/1							
Comments:												

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: Given the infrequent use of crisis intervention chemical restraint, but the relatively high percentage of crisis intervention restraints that use medication, the protections afforded by these indicators need to be implemented. Likely, with proper clerical oversight, proper consultation and follow-up can occur. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	53									

47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/1	0/1								
48	Multiple medications were not used during chemical restraint.	0% 0/1	0/1								
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1								
Comments: 47-49. These indicators applied to a chemical restraint for Individual #53. The review form was noted as unavailable for review. There was no documentation of psychiatric follow-up after 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

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/4	N/A	0/1	0/1	0/1	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments: a. The Center's policies with regard to criteria for the use of TIVA, as well as medical clearance for TIVA need to be expanded and improved. Although these four individuals had evaluations prior to the use of anesthesia, until the Center is implementing related policies, it cannot make assurances that it is following proper procedures. Given the risks involved with TIVA, it is essential that such policies be developed and implemented.

For these four instances of the use of TIVA:

- Informed consent for the TIVA was not presented.
- An operative note defined the procedures and assessment completed.
- Post-operative vital sign flow sheets were submitted for Individual #51, and Individual #124. The flowsheets submitted for

Individual #74 were incomplete. No flowsheets were submitted for Individual #144.

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/6	N/A	0/2	0/2	N/A	0/2	N/A	N/A	N/A	N/A
Comments: a. The Center did not submit evidence that the PCP determined medication and dosage ranges with input from an interdisciplinary committee. Informed consent also was not provided for the pre-treatment medical sedation for the individuals reviewed. On a positive note, nursing staff documented pre- and post vital signs.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: For the three individuals, IDTs commented that desensitization had failed in the past and, therefore, no treatment strategies were warranted. Given this discussion by the IDT, criterion was met for indicator 2, however, the Monitoring Team suggests that other treatment strategies, perhaps other than formal desensitization, might be trialed for one or more of these individuals in the future. In addition, some additional focus is needed by IDTs in order for indicator 1 to meet criteria. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	51	46						
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/3	0/1	0/1	0/1						
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 3/3	1/1	1/1	1/1						
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP	N/A	N/A	N/A	N/A						

	(or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										
4	Action plans were implemented.	N/A	N/A	N/A	N/A						
5	If implemented, progress was monitored.	N/A									
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A						

Comments:
1-6. This outcome and its indicators applied to PTS administered to Individual #142, Individual #51, and Individual #46 on the dates below:

- Individual #142 was administered Ativan/Benadryl on 9/30/17 prior to a dental examination.
- Individual #51 was administered Chloral Hydrate/Benadryl prior to an eye appointment on 1/9/17.
- Individual #46 was administered Benadryl on 6/14/17 prior to a dental procedure.

Available documentation for all three individuals indicated that behavior problems occurred in past when PTS was not used, and that desensitization was unsuccessfully used in the past. PTS usage and effectiveness during the past 12 months and documentation of informed consent, however, were not found for any of these administrations of PTS in their ISPs or ISPAs.

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.			Individuals:									
#	Indicator	Overall Score										
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	N/A										
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: The Center did not appear to have a system to ensure that potential adverse drug reactions were reported immediately, further investigated, and probability scales completed. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	ADRs are reported immediately.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/2	0/1						0/1		
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/2	0/1						0/1		
d.	Reportable ADRs are sent to MedWatch.	0% 0/2	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. However, in reviewing documents the Center submitted, the Monitoring Team identified potential ADRs for two individuals. More specifically:

- In reviewing the QDRR for Individual #114, dated 9/26/17, the Clinical Pharmacist documented low sodium levels, but did not discuss the etiology. Sodium levels of 127 to 128 were documented in the labs. The PCP noted that the hyponatremia was attributed to the use of divalproex, but the Center did not submit an ADR report or follow-up.
- On 10/16/17, the PCP for Individual #143 documented an assessment, and noted that the hypothermia was "considered to be adverse drug reaction orders dated 10/03/17." Topiramate is associated with problems related to temperature regulation. It was notable that no ADR form was submitted.

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: It was good to see that the Center completed two clinically significant dues, which was an improvement from the last two reviews. However, the minutes the Center submitted did not clearly identify any deficiencies the DUEs uncovered, and/or plans to correct the problems noted. These indicators will remain in active	Individuals:

oversight.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	0% 0/2

Comments: a. and b. In the six months prior to the review, Rio Grande State Center completed two DUEs, including:

- A DUE on Valproic Acid, for March through May 2017, and discussed on 7/19/17; and
- A DUE on Lorazepam, for June through August 2017.

While on site, the Monitoring Team requested minutes showing discussion of the DUEs. Of note, the DUEs were completed for individuals residing in the ICF portion as well as the mental health section of Rio Grande State Center. The minutes the Center submitted did not clearly identify any deficiencies the DUEs uncovered, as well as plans to correct the problems noted.

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. At the last review, six of these indicators were moved the category of requiring less oversight. For this review, five other indicators were moved to this category, in ISPs, psychiatry, and skill acquisition.

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

Less than half of the IDTs fully considered what assessments the individual needed and would be relevant to the development of the ISP. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for the great majority of the risk ratings reviewed, 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.

In psychiatry, not all individuals had a comprehensive psychiatric evaluation (CPE). In addition, the content requirements for CPEs needed attention to ensure that all components were included. In behavioral health services, there was improvement (to 100%) in the timeliness and completeness of annual behavioral health assessments and functional assessments. For skill acquisition planning, the required assessments were current for all individuals (FSA, PSI, vocational). Less than half of these assessments, however, included recommendations for skill acquisition plans.

In behavioral health services, ensuring the reliability of data needs to be a priority.

On a positive note, for this review and the two previous reviews, Medical Department staff completed the new admission medical assessments in a timely manner. As a result, the related indicator will be placed in the category requiring less oversight. For this review and the last one, PCPs also completed timely annual medical assessments for the individuals reviewed. The Center is encouraged to sustain this progress.

Center staff should continue to improve the quality of the medical assessments, particularly focusing on family history, and pertinent laboratory information. It was good to see that PCPs had documented clinical justification for the diagnoses reviewed.

It was good to see that all nine individuals reviewed had timely new admission or annual dental exams. Seven of the nine individuals had timely dental summaries. These findings were significant improvements in comparison with the last three reviews. The quality of annual dental exams as well as summaries required continued attention.

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. In addition, often, when individuals experienced changes of status, nurses did not complete assessments consistent with current standards of practice.

The Center should focus on the timely referral of individuals who meet criteria for referral to the PNMT, the completion of PNMT reviews for individuals who need them, and the completion of PNMT comprehensive assessments for individuals who need them. The quality of comprehensive assessments also needs work, particularly with regard to the identification of underlying causes of PNM issues and recommendations to address the causes.

Some improvement was noted with regard to the timeliness of OT/PT assessments. However, all of the OT/PT assessments reviewed showed significant concerns, which were similar to the previous review. It is essential that Center staff improve the quality of these assessments. Center staff are encouraged to review the previous report, as well as the audit tool, and adhere to the requirements when completing assessments.

Although more work was needed, some improvement was noted with regard to the quality of communication assessments. Moving forward, it will be essential to focus on the assessment of the potential for the use of alternative and augmentative (AAC) or environmental control (EC) strategies, including the incorporation of individuals' preferences and strengths into the process.

Individualized Support Plans

ISPs were revised annually for all individuals. The percentage of areas of the ISP for which there were individualized personal goals remained about the same as last time (i.e., in about one-third of the areas). ISP personal goals though did not have a clear set of action plans that would serve as a road map for their ultimate achievement. The Monitoring Team was concerned about the ability of the IDTs to accurately identify and adequately address areas of risk, particularly falls, injuries, and weight. Recent activity to work on health/wellness/IHCP goals was good to see and held some promise for improvement.

Getting ISPs implemented remained a challenge that continued to be a barrier to individuals receiving the actions and supports identified in their ISPs. IDTs recently met to review the status of programs and goals for several of the individuals and reported that they had made substantial revisions to address (1) appropriateness of goals and (2) problems/ barriers to implementation concerns.

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, physical and nutritional support interventions. However, of note, the nurses at Rio Grande State Center made significant progress in terms of including nursing assessment interventions in the IHCPs reviewed. Although continued work is needed in this area, especially regarding the consistency of completing these assessments and using the clinical data proactively, it was good to see the notable improvement since the last review.

Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines.

Meaningful and substantial community integration action plans were largely absent from the ISPs, however, there were reports of improvements in community employment opportunities for individuals. Two individuals had their first day of part-time supported community employment during the week of the onsite review.

There was much progress in the development of individualized psychiatry-related goals. The psychiatrist was utilizing the grid/table format within various psychiatry documents. In addition, a combination of observable behaviors (i.e., PBSP target behaviors) and psychiatry assessment tools (i.e., psychometrically-sound rating scales) were used to identify indicators for determining psychiatric status. The psychiatrist attended about half of the ISP meetings. The psychiatrist attended both an ISP meeting and an ISPA meeting during the onsite week. He contributed greatly to the discussion.

In behavioral health services, all individuals had current PBSPs. About two-thirds of the PBSPs had complete content.

All individuals had at least one skill acquisition plan (SAP), but there was a small number of SAPs for about one-third of the individuals who could have benefited from more skill training. There was improvement in the collection of SAP data that were reliable and useful.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Rio Grande SC IDTs maintained about the same amount/percentage of goals that were personal and individualized and that were written in measurable terminology. Lack of implementation blocked any progress and any ability to determine progress. Recent activity to work on health/wellness/IHCP goals was good to see and held some promise for improvement. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	103	114	97	36	129			
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	2/6	2/6	3/6	2/6	0/6	4/6			
2	The personal goals are measurable.	0% 0/6	0/6	1/6	2/6	2/6	0/6	2/6			
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 #51, Individual #103, Individual #114, Individual #97, Individual #36, Individual #129). 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.

For this review period, none of the six ISPs contained individualized goals in all areas. Therefore, none had a comprehensive set of goals that met criterion. Still, the IDTs continued to work toward developing personal, measurable goals. As reported at the time of the previous monitoring visit, the Center continued to hold a Good Goals meeting that focused on the proposal of personal goals that reflected the findings of the Preferences and Strengths Inventory (PSI). This meeting was held in advance of the ISP Preparation Meeting to ensure the IDT used individuals' preferences in the development of personal goals. The Center had also begun in September 2017 to hold a similar meeting to focus on the development of personal goals in the Integrated Health Care Plan (IHCP). The Monitoring

Team observed a meeting of this latter group while onsite and found the overall approach to brainstorming and identifying needed data and staff action to be encouraging and promising.

While the Center did not make progress in developing a higher percentage of personal goals that met criteria since the previous visit, there was some progress in developing goals that met criterion for measurability, as described further below. It was also positive the IDTs had recently reviewed several of these ISPs, had determined they did not reflect the personal goal requirements outlined above, and were in the process of making significant changes to goals and action plans. For these revisions to be effective, the Monitoring Team encourages the IDTs to also focus on ongoing implementation and monitoring for effectiveness.

1. During the last monitoring visit, the Monitoring Team found 17 personal goals met criterion for being individualized, reflective of the individual's preferences and strengths and based on input from the individual on what is important to him or her. During the current site visit, 13 personal goals met criterion. Findings included:

- The 13 personal goals that met criterion were leisure goals for Individual #51, Individual #103 and Individual #114; relationship goals for Individual #114 and Individual #129; work goals for Individual #97 and Individual #129; independence goals for Individual #51, Individual #114 and Individual #129, and, living options goals for Individual #103, Individual #97 and Individual #129.
- It was positive the IDTs had made attempts to develop personal goals that addressed individual preferences in some domains, such as leisure and living options. Overall, however, considerable work remained to be done in this area, and especially for employment and independence goals.
- Of the remaining personal goals, many were not aspirational. This is described further below.

2. The Monitoring Team reviewed the 13 personal goals that met criterion for indicator 1 and their underlying action plans to evaluate whether they also met criterion for measurability. Of these 13 personal goals, seven also met criterion for measurability.

Personal goals that met criterion included several that were, on their face, measurable. For example, Individual #114 had a leisure goal to make (sew) five shirts. In general, living options goals also met criterion in this regard, describing the type of home, location, and various other characteristics important to the individual. To enhance measurability of these living options goals in the future, the IDTs should further project a timeframe for expected achievement.

Examples of personal goals that did not meet criterion for measurability included:

- The ISP for Individual #51 included a leisure goal to compete in special needs basketball with other individuals in Harlingen. This goal was broad and vague and did not indicate how often or when this was projected to occur. Further, the action plans did not identify a specific plan for or clear path toward his actual participation. The action plans posited that he would need to learn to push his wheelchair, which was later revised to learning to lock his wheelchair, and purchase wristbands. The only other two action plans, to attend local basketball games as an observer and to ensure he remained hydrated and used sunscreen in the event these were outdoor events, had been deferred until November 2017, almost one year after the ISP date. This set of action plans would not allow an observer to determine if any progress was being made toward the goal of participation.
- The ISP for Individual #129 included a relationships goal for her to spend a day with her sister in the community. This goal, as

it was formulated, was not aspirational. With appropriate support, Individual #129 could likely already spend a single day in the community with her sister. The IDT did not specify whether the expectation was that she be able to do this independently or, if so, identify and develop action plans that specifically addressed the barriers that might keep her from doing that. The IDT also did not provide any expectation this would occur with any frequency. The related action plans were limited to a SO for a weekly activity with sister that had no expectation this would occur in the community, and for the QIDP to submit a purchase request for a bin and arts and crafts activities she can work on when her sister came to visit. The IDT did not provide any rationale for why this would support spending a day in the community.

3. For the seven personal goals that met criterion in indicator 1, none had reliable and valid data, due in large part, to lack of implementation. IDTs had failed to develop and implement many of the skill acquisition plans (SAPs) and service objectives (SOs) that formed the implementation methodology for personal goals. Even when SAPs and SOs had been developed, data had often not been collected on a consistent basis.

In the month or so prior to the onsite review, some IDTs had met to review the status of programs and goals for several of the individuals and reported that they had made substantial revisions to address (1) appropriateness of goals and (2) problems/ barriers to implementation concerns. The ISPAs for these activities were not completed yet.

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

Summary: This set of indicators addresses the overall set of action plans in the entire ISP. There were examples where some action plans for some individuals met criteria, but overall, the ISP action plans did not contain the various characteristics that would lead to achievement of personal goals. Scoring for this set of indicators was about the same/lower compared with the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	103	114	97	36	129			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	1/6	0/6	1/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the	0%	0/1	0/1	0/1	0/1	0/1	0/1			

	areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0/6									
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6	0/1	0/1	1/1	1/1	0/1	1/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
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. Most personal goals did not meet criterion, as described under indicator 1 above. For those that did, ISP goals generally did not have a clear set of action plans that would serve as a road map for their ultimate achievement, as described under indicator 2. IDTs also needed to focus on laying out a clear path of assertive action plans to meet each goal. Some goals had minimal action plans that were at best tangentially related to the achievement of the goal. For example:

- Individual #51 had a personal goal to organize a sports themed collection. The sole action plan was a SAP to match color blocks by shape and color.
- Individual #97 had a personal goal in the relationships domain to use proper social interaction (no spitting at or urinating on people) out in public. The sole action plan listed was to call his LARs and asked if they would like him to visit them at the family home with staff monitoring the visit.
- Some other goals did have a good set of action plans that had potential to lead to achievement, but had not been implemented or revised to help support those goals.

9. One of six (Individual #129) ISPs contained a set of action plans that clearly integrated preferences and opportunities for choice. Otherwise, IDTs demonstrated some increased proficiency in developing action plans that integrated preferences, but offered few opportunities for choice-making. Findings included:

- For Individual #129, the IDT developed action plan that supported opportunities to make choices in gardening, shopping for food and shopping for art supplies. It was unfortunate the IDT had not yet implemented these action plans,
- Action plans incorporating preferences included SAPs and SOs related to cars for Individual #103, related to sports and

basketball for Individual #51, and related to music and dancing for Individual #36.

- For Individual #114, the IDT acknowledged she wanted to explore various evangelical churches, but did not develop an action plan that would have supported her desire to choose among churches.

10. None of these six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. Self-advocacy committee can be one venue for developing decision-making skills. Rio Grande SC's self-advocacy committee had been meeting monthly over the review period and the Monitoring Team observed the current month's meeting during the onsite week. The Center also submitted a brief description of the topics discussed at each of the meetings since May 2017. The Rio Grande SC self-advocacy committee had a monthly topic (regarding one particular rights area). The committee and its facilitator might consider incorporating opportunities for decision-making (and for learning how to make decisions), and also developing a regular attendance base; only a handful of individuals attended the meeting during the onsite week.

11. None of six ISPs met criterion for supporting overall independence. Examples included:

- Individual #103's ISP included action plans for a toothbrushing SAP and SAM SAP, both of which were changed to service objectives without a clear justification. Per the available data, he had not mastered the toothbrushing SAP. The SAM was changed to an SO after months in which no data were collected. Overall, the IDT also failed to implement his independence action plans consistently, rendering them ineffective. The sole positive exception was his communication action plan.
- Individual #114's ISP did identify a set of action plans that might have supported increased independence, but the IDT had not developed SAPs or SOs to implement these. The proposed action plans included putting on her stockings independently, use of a microwave, identifying healthy food choices, combining coins and bills and money management community outings, and safety awareness skills. As of the time of the monitoring visit, none of these had yet been implemented and so could not be said to support her increased independence.
- The IDT did not identify an independence goal for Individual #36 and the sole action plan cited in that section was an SO for staff to bush her teeth. Individual #36's ISP did include an SO to decrease her rate of intake at mealtimes by placing a glass of liquid in her left hand (which she held her spoon with). This was a strategy with good potential, but the IDT should have developed this as a SAP to promote learning and independence.

12. The IDTs did not assertively address risk areas in a consistent manner. The Monitoring Team was concerned about the ability of the IDTs to accurately identify and adequately address areas of risk, particularly falls, injuries, and weight.

- The Center's systems for tracking falls did not produce reliable data. The Monitoring Team found repeated instances in which the reported number of falls for individuals (Individual #97, Individual #103, Individual #36, Individual #114) varied significantly across various reports, such as the QIDP monthly review, the PNMT Episode Tracker, the Center's falls database, the IRRF and the Falls Assessment completed by nursing.
- In several instances, the IDTs did not meet to act until after the Center's Incident Management Review Team (IMRT) identified a concerning trend and generated a corrective action plan (CAP). Even then, IDTs did not consistently meet to address the CAP for weeks, well after the due date. The IDT should meet immediately after a CAP is issued to address any protective measures that might be urgently needed, as well as to determine other actions, such as discipline assessments, that may need to be completed or updated, or identification of data that may need to be collected and analyzed. The following examples represented a failure on the part of the IDT, as well as the overall incident management system, to respond to increased risk on

a timely basis.

- For Individual #36, the IMRT issued a CAP on 8/3/17, citing eight falls in the 90-day period from 6/21/17-6/25/17. The CAP indicated the IDT was to meet and respond by 8/17/17. On 10/2/17, the IMRT issued another CAP, this time documenting nine falls in 90 days ranging from 8/2/17-9/20/17. This CAP required the IDT to respond by 10/11/17, but did not reference the previous CAP. The IDT did not meet to address falls until 10/5/17, more than two months after the initial CAP was issued.
- On 9/28/17, the IMRT issued a CAP related to increased number injuries sustained by Individual #103, from four in July 2017 to eight in August 2017, and to review his falls risk. The CAP required the IDT to meet, review the injuries and put supports in place to prevent future injuries by 10/9/17. The IDT did not meet until 10/23/17. The IDT agreed his injuries and falls could be the result of his mania/hyperactivity, which it reported had improved, if somewhat minimally, with the introduction of a new medication. It further indicated that injuries and falls had decreased. The ISPA did not provide detail that would indicate a full analysis of his falls had been completed and the narrative did not provide any rationale as to the IDT's conjecture. The IDT did not complete an IRRF Change of Status (CoS) regarding his existing low risk for osteoporosis/falls/fractures. This current rating did not reflect his actual risk in this area in any event, as the annual medical assessment (AMA) stated he had osteopenia as well as a higher risk of fractures long term due to his medications. He also required calcium and Vitamin D supplementation. The AMA indicated the primary care practitioner (PCP) disagreed with the low rating when it was proposed, but the IDT did not provide a rationale for its decision to retain that rating level in light of these findings.

- Individual #129 had experienced significant weight gain and the IDT had not taken assertive action. From July 2016 to October of 2017, her weight had increased from 126 pounds to 163 pounds. She had met thresholds for PNMT referral on several occasions, including a gain of nine pounds between June 2017 and July 2017, and a gain of 10 pounds between August 2017 and September 2017. She weighed 135 pounds in January 2017 and 153 pounds in July 2017, which should have triggered a PNMT referral for 10 percent change in six months. She met the 10 percent in six months threshold again in August 2017. She weighed 150 pounds in August 2017 and 160 pounds in September 2017, which should have triggered a referral for more than five percent in one month. The IDT had not completed a PNMT referral and the PNMT had not completed an assessment. The IDT did meet finally in October 2017 and discussed a change to her caloric intake on 9/26/17, but IDT had no further recommendations and did not make a PNMT referral.
- Individual #51 had been diagnosed with pituitary adenoma in brain. The IDT had not effectively evaluated his risk in this area or ensured all needed action steps were in place. Per the Monitoring Team's review, the IDT should have included a specific risk rating and assessment in the IRRF and related action plans in the IHCP. As is discussed in other sections of this report, the IDT needed to consider:
  - The tumor could affect his vision. Although he had an annual eye exam, it did not document the diagnosis of macroprolactinoma. The IDT should consider referring him to an ophthalmologist for a visual field screening.
  - He had been seen by an endocrinologist, who referred him to the neurosurgeon, who referred him back to the endocrinologist. It was unclear whether the neurosurgeon understood that Individual #51 already was under the care of an endocrinologist, and/or the reasons the endocrinologist was requesting a neurosurgeon's consultation. The IDT needed to consider and assign an appropriate medical professional to ensure appropriate medical management and advocacy.
  - The tumor produces prolactin and he was also taking medications that elevated prolactin, especially Risperdal. The

IDT needed to assess his medication regimen overall to manage the prolactin levels.
    - The IDT needed to ensure the IHCP included action steps, such as nursing staff monitoring for lactation, for changes to genitalia, and for changes to vision.
    - The IDT needed to consider obtaining a DEXA scan because of his longstanding hyperprolactinemia, which may contribute to increased risk of bone loss.

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, also as described throughout this report. In addition to the examples provided in #11 and #12 above, other examples included:

- In the area of behavioral support needs, the Center had not identified the potential impact of post-traumatic stress disorder (PTSD) for Individual #36. Center staff reported she had sleep disturbance and refused to sleep in her bedroom. In fact, she generally refused to go into her bedroom. This type of behavior can sometimes indicate an individual lacks a sense of security and should at least be explored by the IDT. Upon review, assessments documented a history of home invasion with possible sexual assault when she was a teenager, which the IDT needed to consider.
- In the area of communication, the IDT for Individual #97 had discontinued two leisure SAPs related to using a voice output device to request a ball or to play ball. The ISPA indicated both should be continued as SOs instead, but to continue without data collection. Only one SO, to request the ball in the home, was available. The SO to use his voice output device to request a ball at the gym was not available. The PNMP drafted for his ISP meeting on 11/21/17 included using the voice output to request food and/or drink, but did not include the strategies to use the device to request a ball.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration.

15. Three of six ISPs (Individual #114, Individual #97, Individual #129) considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. Examples of those that did not meet criterion included:

- Per his vocational assessment, Individual #103 liked to have money, was motivated by pay, and would benefit from vocational exploration of possible places of employment in community. The IDT developed a work goal to volunteer at a toy drive, which may have provided some vocational experience, but the ISP did not include any action plans to facilitate actual participation in such activity.
- For Individual #36, the ISP included only a goal and action plan to shred paper. These were based on availability of vocational activity at the Center rather than considering opportunities for day programming in the most integrated setting consistent with Individual #36's preferences and support needs

There were reports of improvements in community employment opportunities for individuals. Two individuals had their first day of part-time supported community employment during the week of the onsite review (Individual #115, Individual #53).

16. None of six ISPs 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. The IDTs did not place significant focus on skill acquisition. Even

when the ISP described a set of opportunities that may have met criterion, the IDTs had failed to develop or implement many of these action plans.

17. The IDT did not consistently address barriers to achieving goals. For example:
    - IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described in indicator 26.
    - For Individual #103, the IDT changed SAPs for toothbrushing and SAMs to SOs after a lack of progress, but provided no evidence or rationale that addressed the barriers to skill acquisition in either of these areas.

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 and data had not been demonstrated to be valid or reliable, 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: With the exception of indicator 22, the indicators of this outcome scored lower than last time or remained at 0%. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	103	114	97	36	129			
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).	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A			

26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	N/A	N/A	0/1	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.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. One of six ISPs (for Individual #114) included a description of the individual's preference for where to live and how that was determined. Otherwise, the IDTs indicated the individuals' preferences were undetermined or unknown, generally based on lack of awareness of community living. For Individual #129, this determination did not appear to be accurate, or at least consistent. The ISP stated in one section that the community living options process (CLOIP) completed by the LIDDA indicated her preference of where to live was undetermined due to limited awareness, but in another section, the narrative reflected Individual #129 was asked by QIDP where she wanted to live and she stated with her sister.

20. One of the six individuals (Individual #97) had an annual ISP meeting during this onsite visit, but the IDT was not able to determine his living options preference. Individual #97 had not been on any community living tours in this past year, despite having had an action plans for group home tours.

21. Overall, none of six ISPs fully included the opinions and recommendation of the IDT's staff members, but progress was noted.

- Assessments typically provided a statement of the opinion and recommendation of the respective team member. This was an indicator of progress, but current assessments by key staff members were sometimes not available at the time of the ISP. For example, the psychiatric assessment updates for were not available at the time of the ISPs for Individual #51, Individual #103, Individual #114, and Individual #97, but all had psychiatric barriers to community living. In addition, the communication screening for Individual #129 did not provide a statement or recommendation regarding community living. In a comment after reviewing the draft version of this report, the State wrote that the Center's communication screening tool does not contain a place for making an opinion regarding community living. That was the case, however, even if the clinician chooses to do a brief assessment in place of a full assessment for the ISP, the clinician must still provide a statement and recommendation regarding community living/most integrated setting options. If the Center's screening tool doesn't allow for that, then the screening tool is not sufficient for planning purposes for the annual ISP.
- ISPs did not always include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For example, for Individual #36, some disciplines (e.g., vocational and FSA) made recommendations against referral based on citizenship status rather than her needs. On the other hand, it was positive that Individual #129's ISP included thorough summaries of most disciplines' recommendation as well as supports that would be needed in the community.

- Five of six ISPs included an overall statement of the IDTs' staff members as a whole. Individual #36's ISP lacked this statement.

22. This indicator met criterion. The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, for all six individuals.

23. None of six individuals had a thorough examination of living options based upon their preferences, needs, and strengths. The ISPs did not reflect a robust discussion of available settings that might meet individuals' needs. Examples included:

- For Individual #51, the IDT did not discuss how to address the LAR's refusal to allow community exploration or the nature of the LAR's concerns regarding community living. The narrative indicated the family/LAR had been willing to allow Individual #51 to participate in group home tours, but changed their minds after speaking to the LIDDA. The IDT should have explored this.
- For Individual #114, the IDT did not document any discussion about a host home as a possible living option, even though she had indicated this was her preference.
- Similarly, for Individual #129, the IDT did not document any discussion of the potential opportunity for her to live with her sister, even though she expressed this was her preference.

24. Two of six ISPs (for Individual #103 and Individual #114) identified a thorough and comprehensive list of obstacles to referral in a manner that would allow for the development of relevant and measurable goals to address the obstacle. For the other four individuals, the IDTs did not include individual awareness as a formal barrier, even though the narrative made clear this was a need in each case.

25. For Individual #97, whose ISP meeting was observed during this onsite visit, the IDT did not identify a full list of obstacles to referral. Per the Monthly Review, his QIDP sent an email on 7/25/17 to the Placement team to include Individual #97 on the list to tour group homes. The monthly review noted the Placement Specialist replied that Individual #97 was "not a good candidate" for tours, as clients in the community might hurt him if he were to spit or urinate on them. The IDT did not identify or discuss this barrier.

26. None of six individuals had individualized, measurable action plans to address obstacles to referral. Action plans to address individual awareness and LAR reluctance did not have individualized measurable action plans with learning objectives or outcomes. For Individual #114, whose barrier was identified as behavioral/psychiatric needs, the IDT did not provide any criteria that would allow for community living to be recommended in the future.

27. During Individual #97's onsite annual ISP meeting observed onsite, the IDT did not discuss or develop action plans to address the barrier to his awareness of community living options as that related to the aforementioned behavioral barrier to group home tours.

28. None of six ISPs had individualized and measurable plans for education.

29. This indicator was not applicable. All six individuals had obstacles identified at the time of the ISP.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.	
Summary: ISPs were revised annually or developed in a timely manner for all	Individuals:

individuals for this review and for the last two reviews, too. Therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. Also positive were improvements in individuals' participation in the planning process and in the make-up/attendance at ISP meetings (indicators 33 and 34). Getting ISPs implemented, however, remained a challenge that continued to be a barrier to individuals receiving the actions and supports identified in their ISPs. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	51	103	114	97	36	129			
30	The ISP was revised at least annually.	100% 5/5	1/1	1/1	N/A	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	N/A	1/1	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).	67% 4/6	1/1	0/1	1/1	1/1	0/1	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.	33% 2/6	0/1	0/1	0/1	1/1	0/1	1/1			

Comments:

30. This indicator met criterion. Annual ISPs were developed on a timely basis.

31. Individual #114 had been recently re-admitted and the IDT held her ISP on a timely basis. This indicator also met criterion.

32. ISPs were not consistently implemented on a timely basis, within 30 days of the ISP meeting, for any of the six individuals. While IDTs filed the completed ISP documents on time, many SAPs, SOs, and action plans were not developed for months after the ISP planning meetings had been held.

33. Four of six individuals participated in their ISP meetings. Per documentation, Individual #103 and Individual #36 did not. The Monitoring Team also observed the ISP for Individual #97 held during this visit. It was positive the IDT had undertaken a series of actions to accommodate and encourage his participation, including special seating, preferred staff to accompany him, and allowing him to become accustomed to the environment before the meeting began. Individual #97 did not stay for the meeting, but the effort by the IDT was commendable. In the future, the IDT may want to consider additional steps, such as holding the meeting in a setting that is already familiar and comfortable for him.

34. Two of six individuals (Individual #97, Individual #129) had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Presence of a full, or near full, IDT at individuals' meetings sets the stage for meaningful discussion. The Monitoring Team observed this for Individual #97 regarding his rock collection, and for Individual #50 regarding possible referral to another SSLC. Other findings included:

- It was positive that the SAP writer attended recent meetings.
- For Individual #114, the IDT did not include the psychiatrist or PCP, but she had significant needs in both areas.
- No OT/PT representative attended Individual #103's ISP meeting, despite at least five falls in the previous year.
- The speech-language pathologist (SLP), did not attend Individual #36's ISP annual meeting, but the independence goal proposed at the time of the ISP Preparation meeting relied heavily on the SLP assessment and input. Per the documentation, the SLP completed an assessment related to the items she would need to work on completing her monthly grooming, dressing, and hygiene routine independently. The IDT could not come to an agreement on this goal and related action plans at the ISP annual meeting, so it did not include this in the ISP. SLP participation could well have assisted the IDT to resolve its concerns.
- Overall, QIDPs did not yet demonstrate knowledge of individuals' plans, particularly as it related to the current status of action plans as well as health and safety risks. Due to staff turnover, individuals largely had newly-assigned QIDPs at the time of the monitoring visit.

Outcome 6: ISP assessments are completed as per the individuals' needs.

Summary: Performance decreased regarding considering what assessments were needed, and remained at about the same low level of performance for obtaining needed assessments. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 51	103	114	97	36	129			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	40% 2/5	0/1	0/1	N/A	0/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	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 two of five individuals. (The ISP reviewed for Individual #114 was an initial plan, so the IDT did not hold an ISP Preparation meeting.) Examples of assessments the IDT should have asked for, based on the individuals' needs, but did not, included:

- For Individual #51, the IDT did not request a behavioral health assessment because he had had few aggressions, but other documentation at that time indicated his falls may have been attention seeking in nature and that he had a positive behavior support plan (PBSP). The IDT indicated it did not request a dental assessment because no dentist was on staff. It did not request an audiology assessment because no audiologist on staff. The IDT should focus on the individual's needs rather than on the availability of the resource.

- For Individual #103, the IDT did not provide ISP Preparation meeting documentation for the current ISP, but did so for the upcoming ISP scheduled for December 2017. For the latter, the IDT did not request an SLP assessment or update even though he received ongoing direct speech therapy, or an OT/PT update despite increasing falls.
- The IDT for Individual #97 did not request a vocational assessment, even though the IDT described his interest in working and anticipated development of work-related personal goal and action plans.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. Findings included:
    - It was positive that many of the assessments the IDT failed to appropriately request, such as those identified above, were, in fact, eventually completed.
    - The Comprehensive Psychiatric Assessments (CPE) were not updated for Individual #51, Individual #103, Individual #114, and Individual #97. The CPE had not been updated for Individual #97 at the time of his 2016 ISP annual meeting and had not been updated for the 2017 annual ISP meeting either, despite significant psychiatric and medication concerns.

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	51	103	114	97	36	129			
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.

That being said, the Center had implemented what could be some helpful format changes to the QIDP Monthly Review. These included, for example, an ISPA tracking grid that included blocks for the date of the ISPA, the reason for the meeting, recommendations made, whether recommendations had been completed and an assessment of whether the actions taken had been effective or if additional actions were needed. Still, that potential usefulness was compromised by the lack of timely completion of the QIDP Monthly Reviews, as described below.

37-38. IDTs did not review and revise the ISPs as needed, which reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports.

- IDTs continued to struggle with timely completion of QIDP Monthly Reviews. Many, if not most, monthly reviews were completed months after their due dates. There is minimal value in completing monthly reviews in that manner because it makes it impossible for teams to monitor and respond to needed changes in a timely manner.

- This was further reflected in the lack of needed responses by the IDT, including the failure to implement programs, the failure to collect data as prescribed and the failure to identify the need for and to make modifications to SAPs and other action plans as needed. Many SAPs and SOs had not been implemented until well after their due dates, if at all.
- Monthly review provided minimal analysis regarding progress or outstanding needs. Follow-up to identified concerns was generally haphazard or absent.
- For all individuals, most action plans for personal goals had been infrequently implemented, if at all. In some cases, these unimplemented plans had been continued from one ISP year to the next without identifying and addressing the barriers that prevented implementation.

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.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	The individual's risk rating is accurate.	22% 4/18	0/2	0/2	0/2	0/2	1/2	2/2	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.	22% 4/18	0/2	0/2	0/2	0/2	1/2	1/2	0/2	1/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #114 – constipation/bowel obstruction, and falls; Individual #51 – weight, and other: hypothyroidism; Individual #124 – skin integrity, and gastrointestinal (GI) problems; Individual #144 – falls, and dental; Individual 3 – constipation/bowel obstruction, and falls; Individual #74 – dental, and choking; Individual #143 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #36 – constipation/bowel obstruction, and falls; and Individual #129 – weight, and falls].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual 3 – constipation/bowel obstruction; Individual #74 – dental, and choking; and Individual #143 – UTIs.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and 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 exception was for Individual #36, whose IDT did a very nice job updating the IRRF with specific details when, on 6/14/17, she was noted to be straining to have a bowel movement and needed interventions initiated. The following individuals did not have changes of status in the specified

risk areas: Individual 3 – constipation/bowel obstruction, Individual #74 – choking, and Individual #129 – falls.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: There was much progress in the development of individualized psychiatry-related goals. The psychiatrist was utilizing the grid/table format within various psychiatry documents. This was good to see. In addition, a combination of observable behaviors (i.e., PBSP target behaviors) and psychiatry assessment tools (i.e., psychometrically-sound rating scales) were used to identify indicators for determining psychiatric status. Additional work is needed to get to criteria as detailed in the comments below and as discussed with the psychiatry staff during the onsite review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
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. There was much progress in the development of individualized psychiatry-related goals. The psychiatrist at this facility had begun to develop symptom-related goals for individuals. These were included in the psychiatric progress notes. These goals were primarily based on scores/outcomes of various psychometrically-sound assessment instruments (in addition to some goals being based upon observable symptoms recorded by direct support staff). This was good to see. These goals need to be integrated into the overall treatment program (i.e., the IHCP and QIDP monthly reviews).

In an effort to obtain psychiatric-symptom related data, the facility psychiatric staff had compiled various assessment instruments. There was documentation of the use of assessment scales in the records of all individuals, with the exception of Individual #53. The assessment scales were being performed quarterly and reviewed/trended in the psychiatric documentation. When utilizing assessment scales, comparison of the assessment results over time and, perhaps more frequently-conducted assessments, is needed in order to make these data more useful in monitoring psychiatric symptoms and individuals' response to medications.

In addition, data were provided to psychiatry regarding behavioral challenges (i.e., PBSP target behaviors).

Psychiatric progress notes routinely documented the review of data regarding both behavioral challenges and assessment scale results. This was also good to see. In the psychiatric clinical encounters observed during this monitoring visit, data were available for review, and there was some discussion regarding the data. The issue is that the data were not specific to an integrated psychiatric treatment goal regarding symptom reduction as well as indicators of prosocial aspects that would indicate progress (or lack of progress).

To reiterate:

- There need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be 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.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPEs had been present for all individuals for past reviews, which resulted in indicator 12 being moved to the category of requiring less oversight. For this review, one-third of the individuals did not have a CPE. Given the Center's long history of meeting this requirement, this indicator will remain in less oversight, however, the psychiatry department should take steps to ensure that every individual has a CPE in order for this indicator to remain in this category. In addition, the content requirements for CPEs needed attention to ensure that all components were included. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B	67% 6/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1
14	CPE content is comprehensive.	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
15	If admitted within two years prior to the onsite review, 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% 0/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	0/1	N/A
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1

	relevant to psychiatric treatment are referenced in the psychiatric documentation.										

Comments:
12-13. Individual #22 and Individual #53 did not have completed CPEs. They were not submitted or available and either need to be obtained or re-done. Individual #97's CPE was not in Appendix B format. It should be noted that this CPE was completed in 1995 and also should be re-done.

14. The Monitoring Team looks for 14 components in the CPE. Five of the evaluations lacked a sufficient history of present illness. This was the most common deficiency. Three evaluations were lacking sufficient information in one element, three evaluations were lacking sufficient information in three elements, and one evaluation was lacking sufficient information in eight elements. One evaluation, regarding Individual #53, was not available for review because it had yet to be completed. The evaluation regarding Individual #22 was noted as an "abbreviated psychiatric assessment pending full psychiatric evaluation." This document was dated 5/30/17. The evaluation regarding Individual #114 met all the requirements.

15. For three individuals admitted in the two years prior to the onsite review, none had psychiatric evaluations performed within 30 days of admission. All three had admission notes authored by nursing and a medical assessment dated the day of admission.

16. There was one individual whose documentation revealed inconsistent diagnoses: Individual #22. Information was not provided for Individual #53.

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

Summary: Performance decreased regarding annual psychiatry updates (indicators 17 and 18), but increased regarding submission of psychiatry information to the team (indicator 19). Psychiatry attendance at ISP meetings and psychiatry information in the ISP document remained about the same as last time. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
17	Status and treatment document was updated within past 12 months.	0% 0/6	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/6	0/1	0/1	0/1	N/A	0/1	0/1	N/A	N/A	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	56% 5/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	0/1	0/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	63% 5/8	1/1	1/1	1/1	0/1	1/1	0/1	0/1	N/A	1/1
21	The final ISP document included the essential elements and showed	0%	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

	evidence of the psychiatrist's active participation in the meeting.	0/8									

Comments:
17-19. The Monitoring Team scores 16 aspects of the annual evaluation document. Six individuals required annual evaluations. None were completed. There were quarterly psychiatric clinical encounters documented within 90 days of the ISP meeting for five of the nine individuals.

20. There was a need for improvement with regard to the psychiatrist's attendance at the ISP meetings. The presence of the psychiatrist would allow for richer discussion during the ISP with regard to the required elements. The psychiatrist attended both an ISP meeting and an ISPA meeting during the onsite week. He contributed greatly to the discussion.

21. The final ISP document did not include the required components showing discussion of: 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 the potential and realized side effects of the medication in addition to the benefits.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.

Summary: The quality of the content of PSPs improved to 100%. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
22. Because none of the individuals in the review group had a PSP, two PSP documents were requested and reviewed. The PSPs regarding Individual #138 and Individual #67 included the required information.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.

Summary: Consent forms were not submitted for any medications for one individual (Individual #50) and for some, but not all, medications for another individual (Individual #51). Therefore, indicator 28, which was in the category of requiring less oversight, showed a decrease in performance. This must be corrected at the time of the next review for it to remain in this category. This also affected the scoring for indicator 29. Attention needs to be paid to the quality of the risk-benefit and non-pharmacologic intervention sections of the consent (indicators 30 and 31, this was the same as last time). On the other hand, overall, HRC was functioning	Individuals:

well for this review and the past two reviews, too, with an exception in May 2016. Therefore, indicator 32 will be move to the category of requiring less oversight. Indicators 29, 30, and 31 will remain in active monitoring.											
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	67% 6/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or 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. In six examples, the consent forms included an attachment that included sufficient medication side effect information. The attachments were not included for the consent forms regarding Individual #97 and Individual #103. There were no consent forms submitted for Individual #50.

30-31. The risk versus benefit discussion was not included in the consent forms. The consent forms did not include alternate and non-pharmacological interventions outside of the PBSP.

32. HRC continued to be an active committee that met each week, included membership and active participation from individuals at the Center, a member of the committee, and involved detailed discussion by all attendees, as observed by the Monitoring Team during the onsite week.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.	
Summary: Rio Grande SC continued to have PBSPs for those who needed them and relevant goals and objectives, too. But there were many problems with the data collection system and with the obtaining of data that were reliable, believable, and trusted. This is an important focus area for the Center (and is also noted in various other comments throughout this report). This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.										
5	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:
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 the reliability of data needs to 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: Rio Grande SC showed improvement on all three of these indicators, with all three rising to 100%. These important foundational components help to set the occasion for good behavioral health programming. They will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
12	The functional assessment is complete.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
10. All individuals had a current behavioral health assessment. All necessary components were addressed between the behavioral health assessment and the functional assessment. In the future, all of the components should be in a single document, that is, in the

annual behavioral health update and include an assessment or review of intellectual ability, an assessment or review of adaptive ability, a screening or review of psychiatric and behavioral status, a review of personal history, and a review of medical status.

11. All individuals had current (written/revised in the last 12 months) functional assessments. This represents a substantial improvement from the last review when 62% of individuals had current functional assessments.

12. All of the functional assessments contained all of the necessary components.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.

Summary: PBSP timely implementation decreased to 0%, but PBSPs were updated and current for all individuals, which was an improvement. Also, the number of PBSPs that were complete also improved since the last review. These latter two activities were due to increased focus by the behavioral health services staff. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
14	The PBSP was current (within the past 12 months).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	78% 7/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1

Comments:

13. Documentation to determine if PBSPs were implemented within 14 days of attaining consents was not available.

14. All individuals had current PBSPs. This represents another notable improvement from the last review when 62% of individuals had 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. Individual #142, Individual #51, Individual #103, Individual #114, Individual #50, Individual #46, and Individual #97's PBSPs were complete.

Individual #22 and Individual #53's PBSPs included the training and reinforcement of replacement behavior as only to occur after targets occurred. The prompting and reinforcement of replacement behavior should occur prior to the occurrence of the target behavior. Additionally, the reinforcement of replacement behaviors should be included in the antecedent section of the PBSPs.

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

Individuals:

services. These indicators will remain in active monitoring for inclusion during the next review.											
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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: Given that for three review periods, PCPs completed timely new admission medical assessments (Round 9 – 100%, Round 10 – 100%, Round 11 – N/A, and Round 12 – 100%), Indicator a will move to the category requiring less oversight. Over this review and the last one, improvement was noted with regard to the timely completion of annual medical assessments. If the Center sustains this progress, Indicator b might move to the category requiring less oversight after the next review. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 3/3	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 6/6	N/A	1/1	N/A	N/A	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	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the											

frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

Outcome 3 – Individuals receive quality routine medical assessments and care.

Summary: Center staff should continue to improve the quality of the medical assessments, particularly focusing on family history and pertinent laboratory information. It was good to see that PCPs had documented clinical justification for the diagnoses reviewed. If the Center sustains this level of performance, Indicator b might move to the category of less oversight after the next review. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, 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, updated active problem lists (although many included items that are not medical problems, such as living in an institution, nail biting, wheelchair dependence, etc.), and plans of care for each active medical problem, when appropriate. Most, but not all included, as applicable, childhood illnesses. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, and pertinent laboratory information. For an annual medical assessment, laboratory information should not be provided by exception (i.e., just abnormal findings), but rather should encompass all pertinent laboratory information.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. It was good to see that clinical justification was present for the diagnoses reviewed.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #114 – diabetes, and other: osteoarthritis of the knees; Individual #51 – osteoporosis, and other: pituitary macroadenoma; Individual #124 – respiratory compromise, and gastrointestinal (GI) problems; Individual #144 – diabetes, and other: renal disease; Individual #3 – cardiac disease, and seizures; Individual #74 – cardiac disease, and osteoporosis; Individual #143 – other: bilateral renal calculi, and

other: hypothermia; Individual #36 – cardiac disease, and constipation/bowel obstruction; and Individual #129– diabetes, and other: hypothyroidism].

As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.

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	114	51	124	144	3	74	143	36	129
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.	17% 3/18	2/2	0/2	0/2	0/2	0/2	1/2	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.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
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 #114 – diabetes, and other: osteoarthritis of the knees; Individual #51 – osteoporosis, and other: pituitary macroadenoma; Individual #124 – respiratory compromise, and GI problems; Individual #144 – diabetes, and other: renal disease; Individual #3 – cardiac disease, and seizures; Individual #74 – cardiac disease, and osteoporosis; Individual #143 – other: bilateral renal calculi, and other: hypothermia; Individual #36 – cardiac disease, and constipation/bowel obstruction; and Individual #129– diabetes, and other: hypothyroidism). The IHCPs that set forth the action steps necessary to address the chronic or at-risk condition from a medical perspective were for: Individual #114 – diabetes, and other: osteoarthritis of the knees; and Individual #74 – osteoporosis. b. As noted above, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.										

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.	
Summary: During this review, improvement was noted with regard to the timely completion of dental exams and dental summaries. The Center should focus on improving the quality of dental exams and summaries. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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.	100% 3/3	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	100% 6/6	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	67% 4/6	N/A	0/1	N/A	N/A	0/1	1/1	1/1	1/1	1/1
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. It was good to see that all nine individuals reviewed had timely new admission or annual dental exams. Seven of the nine individuals had timely dental summaries. These findings were significant improvements in comparison with the last three reviews.

b. It was positive that all of the dental exams reviewed included the following:

- A description of the individual's cooperation; and
- Specific treatment provided.

Most, but not all included:

- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;
- Sedation use;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- A description of periodontal condition;
- Caries risk; and
- Periodontal risk.

Moving forward, the Center should focus on ensuring dental exams include, as applicable:

- Periodontal charting;
- An odontogram;
- A summary of the number of teeth present/missing;
- The recall frequency; and
- A treatment plan.

c. Numerous problems were noted with the dental summaries submitted. Moving forward, the Center should ensure dental summaries include:

- Recommendations related to the need for desensitization or another 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: Some problems were noted with regard to the timeliness of new admission and annual nursing assessments. Nurses also should ensure that they complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
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.	67% 2/3	1/1	N/A	0/1	1/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	67% 4/6	N/A	0/1	N/A	N/A	0/1	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.	88% 7/8	N/A	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing	21%	0/2	0/2	1/2	0/1	0/1	N/A	0/2	1/2	1/2

	assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	3/14									

Comments: a. The following describe some of the problems noted:

- The Center did not provide an annual nursing assessment for Individual #51.
- On 12/7/16, Individual #124 was admitted, and on 1/3/17, the IDT held an initial ISP meeting. The date of the annual nursing assessment was 1/18/17, after the ISP date. No summaries of risk areas were found in the quarterly reviews provided.
- Individual #3's annual nursing assessment, dated 1/24/17, indicated that the ISP meeting was scheduled for 2/1/17. However, the ISP, IRRF, and IHCP were dated 1/26/17.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #114 – constipation/bowel obstruction, and falls; Individual #51 – weight, and other: hypothyroidism; Individual #124 – skin integrity, and GI problems; Individual #144 – falls, and dental; Individual 3 – constipation/bowel obstruction, and falls; Individual #74 – dental, and choking; Individual #143 – constipation/bowel obstruction, and UTIs; Individual #36 – constipation/bowel obstruction, and falls; and Individual #129 – weight, and falls).

None of the annual 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 provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 10/10/17 at 2:24 p.m., an IPN noted that staff found Individual #114 lying on her back on the floor outside Building 502 with her knees slightly bent. She reported that she tripped and fell. The IPN indicated that when touched, she would yell out in pain and "would keep changing the placement of the pain." Although the note indicated that she was "clearly able to move her head, arms and torso without any visible pain," the nurse did not include any assessment data in the IPN.
- Individual #51's IRRF that was developed as part of his ISP, dated 12/13/16, noted he had an unplanned weight loss of 19 pounds during the past ISP year, and in December 2016, he weighed 151.3 pounds. In April 2017, he weighed 137 pounds, but no nursing assessments for weight loss were found in the documentation the Center submitted.
- Overall, Individual #51's IDT had no system in place to monitor for symptoms of thyroid or pituitary adenoma in order to determine changes in status and inform changes in medications/treatments.
- On 4/10/17, the PCP ordered zinc oxide to Individual #124's buttocks twice daily due to chronic diarrhea, and for scratches found to the area. However, no nursing assessment was found or any follow-up assessments noting the condition of his skin.
- On 7/28/17, after Individual #3 returned to the Center from a care facility after surgery, an IPN indicated that he fell. Nursing staff did not document a comprehensive assessment addressing mobility or gait, or a follow-up assessment, since he was post-surgery. Also, no indication was found that the nurse notified the PCP of the fall.
- Since June 2017, Individual #36's ISPAs documented falls and unsteadiness. Nursing staff did not use consistent assessment

criteria to document assessment of her falls and unsteadiness.

- Between July 2016 and her ISP meeting in July 2017, Individual #129 gained 28 pounds. The IDT did not analyze data to determine a potential etiology(ies) for the weight gain. Between July 2017 and October 2017, Individual #129 gained an additional 18 pounds. However, nurses did not conduct assessments, and the IDT did not add weekly weights as an action step in the IHCP.

On a positive note:

- On 4/17/17, the nurse wrote an IPN documenting a nursing assessment consistent with current standards after Individual #124 had a vomiting episode.
- On 6/14/17, a nurse attempted to conduct an assessment of Individual #36 for constipation. The nurse provided good documentation of a partial assessment and an explanation regarding the individual's refusal and behaviors during the assessment.
- On 7/11/17, a nurse wrote an IPN describing a good assessment of Individual #129 for a possible fall.

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: The nurses at Rio Grande State Center made significant progress in terms of including nursing assessment interventions in the IHCPs reviewed. Although continued work is needed in this area, especially regarding the consistency of completing these assessments and using the clinical data proactively, it was good to see the notable improvement since the last review. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	50% 9/18	1/2	1/2	2/2	1/2	2/2	0/2	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).	39% 7/18	0/2	1/2	2/2	0/2	2/2	0/2	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	50%	1/2	1/2	2/2	1/2	2/2	0/2	1/2	1/2	0/2

	indicators to be monitored (e.g., oxygen saturation measurements).	9/18									
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	0/2	1/2	2/2	0/2	1/2	0/2	1/2	0/2	0/2

Comments: b. The IHCPs that included preventative measures were for Individual #114 – constipation/bowel obstruction; Individual #51 – other: hypothyroidism; Individual #124 – skin integrity, and GI problems; Individual #144 – dental; Individual 3 – constipation/bowel obstruction, and falls; Individual #143 – constipation/bowel obstruction; and Individual #36 – falls.

c. The individuals' ISPs/IHCPs that incorporated 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 for Individual #51 – other: hypothyroidism; Individual #124 – skin integrity, and GI problems; Individual 3 – constipation/bowel obstruction, and falls; Individual #143 – constipation/bowel obstruction; and Individual #36 – falls.

e. The ISPs/IHCPs that identified and supported the specific clinical indicators to be monitored were for Individual #114 – constipation/bowel obstruction; Individual #51 – other: hypothyroidism; Individual #124 – skin integrity, and GI problems; Individual #144 – dental; Individual 3 – constipation/bowel obstruction, and falls; Individual #143 – constipation/bowel obstruction; and Individual #36 – falls.

f. The ISPs/IHCPs that identified the frequency of monitoring/review of progress were for Individual #51 – other: hypothyroidism; Individual #124 – skin integrity, and GI problems; Individual 3 – constipation/bowel obstruction; and Individual #143 – 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: The Center should focus on the timely referral of individuals who meet criteria for referral to the PNMT, the completion of PNMT reviews for individuals who need them, and the completion of PNMT comprehensive assessments for individuals who need them. The quality of comprehensive assessments also needs work, particularly with regard to the identification of underlying causes of PNM issues and recommendations to address the causes. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	17% 1/6	N/A	0/1	0/1	N/A	N/A	N/A	0/1	1/2	0/1

b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	40% 2/5		0/1	0/1				N/A	2/2	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	25% 1/4		0/1	0/1				1/1	0/1	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 3/6		0/1	1/1				1/1	1/2	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	50% 1/2		0/1	N/A				1/1	N/A	N/A
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	50% 3/6		0/1	1/1				1/1	1/2	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	25% 1/4		0/1	N/A				N/A	1/2	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4		0/1	0/1				0/1	0/1	N/A

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

- Since February 2017, the PNMT followed Individual #51 related to gradual weight loss over the previous year, but it did not appear that the PNMT conducted a thorough review of this year-long weight loss, or a review of his weight loss from 153 pounds to 137.20 pounds that occurred when he was hospitalized from 3/31/17 to 4/12/17. This most recent weight loss was nearly a 16-pound weight loss that should have triggered at least a review. On 4/17/17, the PNMT RN completed a post-hospitalization assessment. The PNMT discussed him in their subsequent meeting, but only in a manner to identify if a review or assessment were indicated. Without a thorough review, it was unclear whether or not a comprehensive assessment was warranted. The Center did not submit any evidence to show that the PNMT tracked his weight following this hospitalization, although it appeared that he rebounded quickly. Weight inconsistencies continued with steady weight gain noted since 6/26/17.
- Upon his admission to Rio Grande SC on 12/7/16, Individual #124 weighed 135 pounds. On 1/6/17, he met criteria for referral to PNMT, when he had lost seven pounds in one month (i.e., more than 5% weight loss). On 4/15/17, his weight of 122.8 pounds showed continued weight loss. It was not until 5/2/17, that his IDT referred him to the PNMT. Based on review of the minutes, on 5/2/17, the PNMT conducted a review, but this information was not included in documents that are readily

available to the IDT (i.e., IPNs). Appropriately, the PNMT decided to conduct a comprehensive assessment, and involved the necessary team members. Issues with the quality of the assessment the PNMT completed are discussed below.

- From 9/28/17 to 10/3/17, Individual #143 was hospitalized with a PEG-tube placement for supplemental nutrition and hydration. On 10/4/17, the RN completed a post-hospitalization review. On 10/9/17, which was one day outside of the required timeframe for PNMT referral or self-referral, his IDT met to review the hospitalization, and referred him to the PNMT for malnutrition/dehydration/change in mobility status. On 10/10/17, the PNMT reviewed him, and decided to complete a comprehensive assessment. On 11/7/17, the PNMT completed its full assessment, which is discussed in more detail below.
- Individual #36 met criteria for PNMT referral twice:
    - On 5/9/17, the PNMT completed a review due to a weight gain of 18 pounds in the past year. She reportedly took unattended food and food from her peers. She also was prescribed several antipsychotics and oral contraceptives that might contribute to weight gain. The review the PNMT conducted for this issue was to the depth and complexity necessary to meet her needs.
    - Different documents that the Center submitted listed different numbers of falls, and different dates for falls. However, it appeared that Individual #36 fell as many as seven times in June, between one and five times in July, six times in August, seven times in September, and seven times in October. On 6/25/17, the PCP ordered that she use a wheelchair as needed. However, it was not until 10/5/17, that the PNMT conducted a review. This review did not include a review of her motor skill performance. Although one theory was that a decrease in Individual #36's Lamictal in June 2017 was the cause of the increase in falls, without at least ruling out changes in her motor skills, it is unclear how the PNMT concluded that a comprehensive assessment was not warranted. Moreover, the PNMT provides a forum for thorough interdisciplinary review that would have been helpful to the IDT given the significant risk at which her falls and additional "near falls" placed Individual #36.
- Individual #129met criteria for referral to the PNMT in August with weight loss from 157 pounds in July to 148 in August, but her IDT did not refer her. She met criteria again for weight gain in September when her weight increased from 148 to 162 pounds, but her IDT did not refer her.

h. As noted above, two individuals who potentially should have had comprehensive PNMT assessments did not (i.e., Individual #51, and Individual #36). On a positive note, the two PNMT assessments reviewed both included:

- The presenting problem;
- Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Evidence of observation of the individual's supports at his/her program areas;
- Assessment of current physical status; and
- Discussion as to whether existing supports were effective or appropriate.

The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- The PNMT assessment conducted for Individual #124 did not identify the etiology of his weight loss, and, as such, the recommendations and the measurable goals were not based on evidence and it was unclear whether or not these strategies might reasonably address his weight loss concerns. Measurable outcomes related to pulmonary ventilation, irritation of the rectal area, and keeping medical appointments were offered with little to no data or discussion of these issues.

- For Individual #143, the PNMT assessment presented considerable information about his medical history and status leading up to the tube placement. The assessment consisted of many notes from other assessors cut and pasted into the PNMT assessment with little to no analysis of how they fit together or their relevance to his change in status. As a result, the PNMT seemed to relate the etiology to a peer-to-peer altercation, but did not site a specific injury or assessment to rule out injury, but rather that the altercation likely caused him some "discomfort" and he began to show signs of weakness. He ultimately had a tube placed, but had returned to by mouth (PO) intake with improvement noted. There was no discussion of a plan to return to oral intake or maintenance of this, and a goal was to encourage him to take in as much as possible with supplementation by PEG tube when he consumed less than 50% of his meal. Actual goals listed in that section of the evaluation, however, addressed standing transfers, ambulation, increased upper extremity strength as evidenced by eating with utensils, and to maintain water balance and caloric intake as evidenced by serum albumin and plasma osmolality. None of these were clearly established as relating to the etiology of the initial reason for referral.

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 needs.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
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).	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 plan includes preventative interventions to minimize the condition 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 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.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	17% 3/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	1/2	1/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/16	0/2	0/2	N/A	0/2	0/2	0/2	1/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	0/2	0/2	2/2	0/2	0/2	0/2	0/2	0/2	2/2

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: choking, and falls for Individual #114; choking, and weight for

Individual #51; GI problems, and weight for Individual #124; falls, and weight for Individual #144; aspiration, and falls for Individual #3; choking, and falls for Individual #74; falls, and aspiration for Individual #143; falls, and weight for Individual #36; and falls, and weight for Individual #129.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks.

c. Although some improvements were noted with the PNMPs and/or Dining Plans reviewed in comparison with previous reviews, none of the PNMPs fully addressed the individuals' needs. Individual #114's PNMP was particularly problematic in that it was missing a number of components, included incorrect or conflicting information in comparison to other documents, and at times, provided incomplete instructions. On a positive note, all of the PNMPs/Dining Plans reviewed had been updated in the last 12 months, and included instructions related to transfers. As applicable to the individual, most included: descriptions of adaptive equipment the individuals used; positioning instructions; instructions related to mobility; handling precautions and moving instructions; bathing instructions; toileting instructions, including personal care; mealtime instructions (including both oral and non-oral means); medication administration instructions (including positioning, texture, consistency, and adaptive equipment); and oral hygiene instructions, including positioning and brushing instructions. Significant problems were noted with regard to, as applicable to the individuals: lack of complete and accurate risk levels related to supports and individual triggers or signs and symptoms; photographs that did not provide clear reference for staff, because they were too small (this has been discussed in previous reports); and lack of information about communication strategies.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for aspiration for Individual #143, weight for Individual #36, and weight for Individual #129.

f. The IHCP that identified triggers and actions to take should they occur was for aspiration for Individual #143.

g. Often, the IHCPs reviewed did not include PNMP monitoring, or did not define the frequency of PNMP monitoring. Those that did were for GI problems, and weight for Individual #124; and falls, and weight for Individual #129.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

	discussion regarding the potential of the individual's return to oral intake.										
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1							0/1		
Comments: a. and b. Individual #143's PNMP indicated that oral feeding would precede PEG-tube feeding, but provided no other guidelines. In addition, his IHCPs did not outline the parameters for the use of the tube.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Some improvement was noted with regard to the timeliness of OT/PT assessments. However, all of the OT/PT assessments reviewed showed significant concerns, which were similar to the previous review. It is essential that Center staff improve the quality of these assessments. Center staff are encouraged to review the previous report, as well as the audit tool, and adhere to the requirements when completing assessments. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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.	67% 2/3	0/1	N/A	1/1	1/1	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.	67% 2/3	0/1	N/A	1/1	1/1	N/A		N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	60% 3/5	N/A	0/1	N/A	N/A	0/1		1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	38% 3/8	0/1	0/1	1/1	1/1	0/1		0/1	1/1	0/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or	N/A									

	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.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	0/1	0/1	0/1	0/1	0/1		N/A	0/1	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/4	N/A	0/1	N/A	N/A	0/1		0/1	N/A	0/1

Comments: a. and b. The following concerns were noted:

- Upon Individual #114's return to the Center after a failed community transition, the OT/PT conducted an update, when a comprehensive assessment was warranted. Individual #114 had lost skills related to ambulation.
- For his ISP meeting on 12/12/16, Individual #51 had an OT/PT assessment, which was timely, and did not recommend any direct PT. However, it appeared that he experienced a change of status requiring reassessment. A brief IPN (which it appeared the PT wrote on 3/9/17, but signed on 3/7/17) recommended direct PT two times a week for eight weeks. The rationale was that the PCP had written orders, but no date for the orders was cited in the IPN. The IPN stated: "in the beginning," he had low pulse rates, but did not state when this was or what the rates were. The PT documented that Individual #51 was stable and that Plan of Care could be presented, but the PT did not indicate what need the plan would address. On 3/12/17, a second consult evaluation was completed recommending direct PT three times a week for four weeks. In each of these documents, the recommended goals were similar, but different. The PT provided no rationale for the variations in the frequency, duration, and/or content of the stated goals.
- For his ISP meeting in January 2017, Individual #3 had a timely assessment. However, his IDT identified mobility concerns as early as February 2017, but he did not have an OT/PT update until June 2017.
- The Center did not submit Individual #129and Individual #143's previous comprehensive assessments, so the Monitoring Team could not determine whether the updates submitted were the correct type of assessments to meet their needs.

d. and e. As noted above, Individual #114 should have had a comprehensive assessment, but did not. The Monitoring Team reviewed comprehensive OT/PT assessments for six individuals, and OT/PT updates for four individuals. All of them showed significant

concerns, which were similar to the previous review. It is essential that Center staff improve the quality of these assessments. Center staff are encouraged to review the previous report, as well as the audit tool, and adhere to the requirements when completing assessments.

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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	13% 1/8	0/1	0/1	0/1	0/1	1/1	N/R	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	50% 4/8	0/1	0/1	1/1	1/1	0/1		1/1	0/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	22% 2/9	0/1	1/1	0/1	0/1	0/1		1/2	0/2	N/A
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% 0/5	N/A	0/1	N/A	N/A	0/2		0/2	N/A	N/A
Comments: c. and d. Often IDTs did not include recommended OT/PT strategies and interventions in ISPs, and/or hold ISPA meetings to discuss and approve recommended OT/PT services.											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Although more work was needed, some improvement was noted with regard to the quality of communication assessments. Moving forward, it will be essential to focus on the assessment of the potential for the use of AAC or EC strategies, including the incorporation of individuals' preferences and strengths into the process. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	Individual receives timely communication screening and/or										

	assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 3/3	1/1	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	67% 4/6	N/A	0/1	N/A	N/A	1/1	0/1	1/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	67% 6/9	1/1	0/1	0/1	1/1	0/1	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.	67% 2/3	1/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	1/1
d.	Individual receives quality Comprehensive Assessment.	40% 2/5	N/A	N/A	0/1	1/1	N/A	1/1	0/1	0/1	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A
Comments: a. through c. The following provides information about problems noted: • The Speech Language Pathologist completed a screening for Individual #124. He had communication deficits, and justification was not provided for not completing a comprehensive assessment. More specifically, based on the information in the											

screening, Individual #124 could only respond to simple verbal requests and use single words or simple phrases. There was no assessment to determine if he had the potential to expand on these basic communication skills and no supports were recommended to assist him in doing so.

- Individual #51's communication assessment was not finalized until the day of his ISP meeting. In addition, the Center did not provide a copy of the comprehensive assessment, so the Monitoring Team could not determine the appropriateness of an update.
- For his ISP meeting held on 10/11/16, Individual #74's assessment was one day late. The update was completed on 9/28/16 for an ISP meeting held on 10/11/16. The SLP had completed a more recent assessment for an ISP that was not yet complete, and, therefore, not submitted, so it was not considered for this review. However, based on information provided, although the assessment was signed on 9/26/17 for an ISP meeting on 10/10/17, it was incomplete at the time. The SLP did not finalize it until four days after the ISP meeting. On 10/14/17, the SLP added direct therapy information, and corrected measurable goal information.
- For Individual #3, the Center did not provide evidence of when the last comprehensive assessment was completed, so the Monitoring Team could not determine the appropriateness of an update.

d. It was positive that Individual #144 and Individual #74 had communication assessments that thoroughly addressed their strengths, needs, and preferences. As noted above, Individual #124 should have had a comprehensive assessment, but did not. The following describes some of the concerns with the two assessments reviewed:

- The individual's preferences and strengths are used in the development of communication supports and services: The SLP did not explore Individual #143's preferences and motivation to address his communication needs and/or incorporate meaningful activities into the assessment process. Based on the assessment information, the SLP appeared to only evaluate him for use of a fan switch and then made the determination that he did not have potential to expand his communication skills and abilities;
- 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: Both assessments included limited exploration of AAC or SAP trials; 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: Given that complete assessments were not available of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, both assessments provided:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills;
- A comparative analysis of current communication function with previous assessments;
- The effectiveness of current supports, including monitoring findings; and
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

e. The following provides examples of concerns noted with regard to the required components of the communication updates reviewed:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Neither update addressed the individual's current health status;
- The individual's preferences and strengths are used in the development of communication supports and services: The updates listed the individuals' preferences and strengths, but did not use them in the development of supports and services;
- 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 #51's update did not discuss expansion of his communication abilities/skills;
- Assessment of communication needs (including AAC, 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: Without sufficient justification, the SLP concluded that Individual #51 would not benefit from AAC or EC strategies; 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: Given that complete assessments were not available of individuals' communication needs, it was unclear whether or not the assessments included a full set of recommendations to address individuals' needs.

On a positive note, the updates sufficiently addressed, as applicable:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- The effectiveness of current supports, including monitoring findings.

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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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.	67% 6/9	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	50% 3/6	N/A	0/1	N/A	1/1	1/1	0/1	1/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs)	38% 3/8	N/A	0/1	N/A	0/1	0/1	1/3	1/1	1/1	N/A

	recommended in the assessment.										
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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: a. Although more work was needed, it was positive that a number of individuals' ISPs provided thorough descriptions of how the individual functionally communicated, and how others should communicate with the individual.

b. At times, although ISPs indicated that the IDT updated and approved the Communication Dictionary, the ISPs included no discussion of what the review or updates included.

c. For some individuals (i.e., Individual #74 – two goals, and Individual #144), their ISPs included narrative indicating the IDT approved communication goals/objectives, but the ISP action plan did not include them.

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: All individuals had at least one SAP, resulting in the high score for indicator 1, but given the small number of SAPs for three of the individuals, who could have benefited from more skill training, as well as the low scores regarding SAPs being practical, functional, and meaningful, indicators 1-4 will remain in active monitoring. On the other hand, although indicator 5 had a low score, it was the highest score yet for Rio Grande SC and reflected the recent initiation of actions to collect data that were reliable and useful. This indicator will also remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
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.	86% 19/22	1/2	2/3	2/3	1/1	3/3	3/3	1/1	3/3	3/3
3	The individual's SAPs were based on assessment results.	82% 18/22	2/2	2/3	2/3	0/1	3/3	3/3	1/1	2/3	3/3
4	SAPs are practical, functional, and meaningful.	68% 15/22	2/2	2/3	1/3	1/1	0/3	3/3	1/1	3/3	2/3
5	Reliable and valid data are available that report/summarize the	18%	0/2	1/3	2/3	0/1	0/3	0/3	1/1	0/3	0/3

	individual's status and progress.	4/22										

Comments:

1. All individuals had skill acquisition plans (SAPs). The Monitoring Team chooses three current SAPs for each individual for review. There were two SAPs available for review for Individual #142, and one SAP each for Individual #22 and Individual #114, for a total of 22 SAPS for this review.

2. Most SAPs were written to include measurable terms. The objectives for Individual #142's make a smoothie SAP, and Individual #103's state the reasons he takes Colace SAP did not include the desired prompt level. The objective for Individual #51's turn on the TV SAP was from another SAP.

3. Most SAPs were based on assessments. There was no evidence of assessments conducted for Individual #53's ride her bike SAP, Individual #114's sewing SAP, Individual #103's state the reasons he takes Colace SAP, or Individual #51's match shapes SAP.

4. Sixty-eight percent of the SAPs were rated as practical and functional (e.g., Individual #51's push his wheelchair SAP). The SAPs that were judged not to be practical or functional where not clearly related to the individual's overall ISP goals (e.g., Individual #51's match shapes/colors SAP).

5. It was encouraging to learn that the behavioral health department recently initiated integrity and reliability assessments for SAPs and that some SAPs in the review group had reliable data. At this point it is recommended that a plan to ensure that all SAPs at Rio Grande SC will be assessed at least every six months should be established.

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: The three required assessments were current for all individuals for this review, for the last review, and for most individuals for the review prior to that. Therefore, indicator 10 will be moved to the category of requiring less oversight. The other two indicators showed improvement since the last review; they will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
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.	67% 6/9	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
12	These assessments included recommendations for skill acquisition.	44% 4/9	0/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1

Comments:

11. Individual #53's FSA, Individual #51's PSI, and Individual #103's PSI and FSA were not available to the IDT at least 10 days prior to their ISPs.

12. Individual #22, Individual #97, Individual #46, and Individual #51'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. At the last review, nine of these indicators were moved to the category of requiring less oversight. For this review, two other indicators were added to this category, in medical and dental.

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.

There continued to be stable long-term psychiatric staff at Rio Grande SC. In addition, psychiatric residents were rounding at the Center. They were supervised by the Center's psychiatrist. This is very positive, not only for the individuals and for the residents themselves, but may spark career interests for psychiatrists to want to specialize with this population.

Goals/Objectives and Review of Progress

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, integrated progress reports, including data and analysis of the data, often were not available to IDTs. 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.

Rio Grande SC now conducted Reiss screens for all individuals who were not receiving psychiatric services. Psychiatry was very involved with behavioral health service and care was coordinated. Better coordination of care with neurology consultation was needed.

Psychiatry quarterly reviews were completed in a timely manner, and documentation was complete, including all the necessary components. The quarterly clinical documentation was a strength at this facility. Quarterly medication reviews (QMR) were observed by the Monitoring Team. They were thorough reviews, individualized, lasted about 45-minutes or so per individual, included lots of attendance from the IDT, there was leadership from the psychiatrist, and there was discussion of various non-pharmacologic factors and interventions, too. The polypharmacy committee continued to be well run and accomplish the goals expected of a polypharmacy committee.

Rio Grande SC improved in the review of behavioral programming by behavioral health services staff. There were now useful graphic summaries of data (though much work was needed to improve the reliability of the data that are collected and summarized). Rio Grande SC, however, was not holding peer review meetings that met the intent (and requirements) for this type of review.

Acute Illnesses/Occurrences

There was only one occurrence of an individual having more than three restraints in any rolling 30-day period and, for this case, it was during the first two days of a new admission. This near-zero rate of occurrence of frequent restraint was positive to see. Even so, some of the requirements for review and treatment considerations were not met.

It was good to see that that nursing staff timely notified the practitioner/physician of signs and symptom of an acute occurrence in accordance with the nursing guidelines for notification. 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. Nursing staff also need to improve the quality of acute care plans.

Some positives were noted with regard to the Center's handling of acute events requiring transfers to an ED or a hospitalization, including that for acute events reviewed: 1) Center staff provided timely treatment and/or interventions for the acute illness requiring out-of-home care; and 2) for events that occurred during business hours, the PCPs completed timely evaluations, and for others, the PCPs wrote IPNs with summaries of events leading up to the acute events and the dispositions. However, problems continued to be noted with regard to the quality of PCPs' assessment of acute issues, as well as their follow-up to acute illnesses and occurrences. In addition, IDTs need to focus on holding post-hospital ISPA meetings to addresses follow-up medical and healthcare supports to reduce risks and promote early recognition, as appropriate.

In psychiatry, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments) were developed and implemented.

Implementation of Plans

As noted above, although more work was needed, it was good to see improvement with the inclusion of regular assessments in alignment with nursing guidelines and current standards of care in individuals' IHCPs. However, data often were not available to show that nursing interventions were implemented thoroughly. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk.

Work is needed to ensure that for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCP identifies the necessary treatment(s), interventions, and strategies, as appropriate. Overall, IHCPs also did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.

For this review and the last one, PCPs generally indicated agreement or disagreement with consultation recommendations, did so in a timely manner, and often wrote an IPN that included the necessary components, which was positive. In addition, for this

review and the last two, when PCPs agreed with consultation recommendations, evidence was generally found to show PCPs ordered the recommendations. Therefore, the related indicator will move to less oversight. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

It was good to see that the PCP completed thorough risk reviews for individuals at risk due to the use of benzodiazepines, anticholinergics, and polypharmacy, and/or with metabolic as well as endocrine risks. However, problems continued to be noted with regard to how metabolic risk was calculated.

During this review and the previous two reviews, individuals reviewed generally received needed dental x-rays, so the related indicator will move to the category of less oversight. However, improvements were needed in the provision of other dental care, such as prophylactic care, fluoride applications, the development and implementation of plans to address periodontal disease, and assessments for dentures for individuals with missing teeth.

Based on the individuals reviewed, the Clinical Pharmacist completed Quarterly Drug Regimen Reviews (QDRRs) in a timely manner, which was a significant improvement from the last two reviews. Improvement is needed with regard to the quality of the QDRRs, particularly the review of laboratory results, and new generation antipsychotic use, as well as the inclusion of recommendations, as appropriate.

It was concerning that some individuals observed did not have prescribed adaptive equipment, some individuals were using equipment that was not included in their PNMPs, and some individuals had adaptive equipment that did not appear to fit them well. Center staff are encouraged to address these issues quickly.

Based on observations, there were still numerous instances (51% of 47 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.

In behavioral health services, without reliable data, it was impossible to assess progress. Much attention needs to be paid to the data collection system for target behaviors and for replacement behaviors. The current system competes with the ability of staff to easily, correctly, accurately, and reliably record data (as noted in many places in this report). The Monitoring Team provided feedback and suggestions for improvement during the onsite review, at the exit presentation, and in the comments below.

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: There was only one occurrence of an individual having more than three restraints in any rolling 30-day period and, for this case, it was during the first two days of a new admission. This near-zero rate of occurrence of frequent restraint was positive to see. Even so, some of the requirements of this outcome and its set of indicators were not met. The restraint management program at Rio Grande SC should ensure that these requirements are met when frequent restraint occurs, even if that occurrence is rare. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	53								
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% 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% 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.	0% 0/1	0/1								
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.	0% 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?	100% 1/1	1/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining	100% 1/1	1/1								

	the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.										
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 1/1	1/1								
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	N/A	N/A								
26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.	N/A	N/A								
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/1	0/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	N/A	N/A								

Comments:
This outcome and its indicators applied to Individual #53.

18. Individual #53 was restrained six times between 9/10/17 and 9/11/17. Her IDT met to review more than three restraints in 30 days on 9/15/17.

20. Individual #53's IDT hypothesized that refusing her psychiatric medications contributed to the occurrence of her dangerous target behaviors that provoked restraint. No actions, however, were presented to address how medication refusal would be addressed in the future.

21. Contributing environmental variables were not discussed in Individual #53's ISPA for more than three restraints in 30 days.

22. Individual #53's ISPA identified her mother's phone calls as an antecedent event that potentially contributed to her restraints. Additionally, the IDT suggested scheduling those calls to address this hypothesized antecedent to Individual #53's dangerous behaviors that provoked restraint.

23. Individual #53's ISPA identified accessing attention as a potentially maintaining her restraints. Additionally, the team recommended that staff instructions to address attention motivated behavior be included in her PBSP.

25. Individual #53 was admitted on 9/7/17, and her only restraints were on 9/10/17 and 9/11/17. Therefore, a CIP was not required at this time.

28. Individual #53 did not have treatment integrity data.

29. Individual #53's PBSP was not completed at the time of the ISPA to review more than three restraints in 30 days.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.

Summary: Rio Grande SC now conducted Reiss screens for all individuals who were not receiving psychiatric services. This was evidenced by the 100% score on indicator 1, an improvement from previous reviews' scores of 0%. This indicator will remain in active monitoring as will indicators 2 and 3 for review at the next onsite visit.

#	Indicator	Overall Score	Individuals: 74	143							
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2	1/1	1/1							
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. These individuals, Individual #74 and Individual #143 were assessed utilizing the Reiss screen. Both of these assessments were initial screenings. Reiss screen scores indicated that no additional evaluation was necessary.

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 that met criteria with outcome 1, 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.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
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% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
11	Activity and/or revisions to treatment were implemented.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

Comments:
8-9. Without measurable goals and objectives yet at criteria for indicators 4-7, progress could not be determined. Thus, the first two indicators in this outcome 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 (e.g., medication adjustments) were developed and implemented. This was the case for all individuals in the review group with the exception of Individual #53. There was no psychiatric documentation presented for Individual #53 that was relevant to this outcome and its indicators primarily because she was a new admission. Therefore, she was rated N/A for these indicators.

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. These indicators will remain in active monitoring, but with sustained high performance, might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

Comments:
23. The target behaviors (e.g., behavioral challenges) identified for monitoring were consistent, and the functional assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors. In addition, the psychiatric documentation routinely identified psychiatric symptoms for monitoring and identified how these would be assessed.

24. There was documentation or indication that the psychiatric provider participated in the development of the PBSP for all of the individuals. There was no PBSP or psychiatric documentation presented for Individual #53. The psychiatrist was noted to discuss the PBSP during psychiatry clinic and comment on this discussion in the documentation.

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: Status remained the same as during the last review. Some attention needs to be paid to this need for coordination. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	50% 1/2	N/A	1/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A
26	Frequency was at least annual.	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/2	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
25 and 27. These indicators applied to two of the individuals. Neurology clinic for this facility occurred in the community, making collaboration a challenge. Individual #51 and Individual #103 were both seen in neurology clinic within the last year.

- In the case of Individual #51, there was documentation of a diagnosis of a pituitary adenoma and consistently elevated prolactin levels. This individual was prescribed the antipsychotic medication Risperdal, which is known to further elevate prolactin levels.
- In the record for Individual #103, there was documentation from neurology indicating that the antiepileptic medication should be continued, however, the medication was apparently discontinued in the absence of ongoing and more recent neurology consultation.

26. This indicator applied to two individuals and met the annual criterion.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: All three indicators improved to 100% for the first time. Quarterly reviews at Rio Grande SC were comprehensive, led by the psychiatrist, and included lots of team members and lots of discussion. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
33	Quarterly reviews were completed quarterly.	100% 6/6	1/1	1/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1
34	Quarterly reviews contained required content.	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

		8/8									
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
33. Quarterly reviews were completed in a timely manner. Individual #53, Individual #22, and Individual #114 had been admitted within the previous three months, two months, and six months, respectively. As such, it was too soon to determine a pattern of compliance with regard to quarterly evaluations for these three individuals.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were complete and included all the necessary components. The quarterly clinical documentation was a real strength at this facility.

35. Psychiatry clinic was observed for one individual. This clinic, regarding Individual #142, was comprehensive as has been the case at Rio Grande SC. These were called quarterly medication reviews (QMR). They were thorough reviews; they were individualized, last about 45-minutes or so per individual, included lots of attendance from the IDT, there was leadership from the psychiatrist, and there was discussion of various non-pharmacologic factors and interventions, too. These reviews and the participation of the psychiatrist in team discussions continued to also be a strength in the clinical program at Rio Grande SC.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.

Summary: The four sub-indicators regarding assessment completion and review were met for all individuals for all requirements, with one exception. This was an improvement from the last review. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
36. Assessments and the prescriber review of assessments were generally occurring in a timely manner. This facility had continued to utilize the DISCUS to screen for abnormal movements. This screen was not done for Individual #51 for one recent required period.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.

Summary:

#	Indicator	Overall Score	Individuals:								
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										

39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	

Comments:
37-39. The psychiatry clinic staff did a good job of scheduling follow-up appointments and ensuring that individuals were returned to clinic as necessary. There was one example, regarding Individual #22, where the psychiatrist requested a follow-up clinic in two weeks, but it did not occur for approximately six weeks. Follow-up/interim clinical encounters were relatively informal. Specific data were not presented. Actions were generally determined via anecdotal information.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:

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: One individual was not reviewed by polypharmacy (Individual #53). Otherwise, the polypharmacy committee continued to be well run and accomplish the goals expected of a polypharmacy committee. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication	80% 4/5	N/A	N/A	1/1	1/1	N/A	1/1	N/A	0/1	1/1

	changes, or (b) at least annually if stable and polypharmacy has been justified.										

Comments:
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. The polypharmacy committee meeting was observed during the visit. This meeting was well run, comprehensive, and organized. The committee compiled recommendations for the treating psychiatrist to review and respond to the committee. This has historically been a good polypharmacy committee and continued to be so.

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: Without reliable data, it is impossible to assess progress. However, the Monitoring Team rated indicators 7, 8, and 9 based upon the Center's own reports. All four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
6	The individual is making expected progress	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	50% 1/2	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	0/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	67% 2/3	N/A	1/1	N/A	N/A	1/1	0/1	N/A	N/A	N/A
9	Activity and/or revisions to treatment were implemented.	100% 2/2	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
6. Individual #51, Individual #114, Individual #50, and Individual #46 were not making progress on one or more PBSP target behavior objectives. There was insufficient PBSP data to determine if Individual #53 was progressing, however, the data were not demonstrated to be reliable (indicator #5), so she was scored as not progressing. Individual #142, Individual #22, Individual #103, and Individual #97's progress notes indicated that they were making progress on their target behaviors, however, the data were not demonstrated to be reliable, so these individuals were also not scored as progressing.

7. Individual #103's sexual acting out objective was reported as achieved in September 2017, and the progress note indicated that the objective would be revised. Individual #97, on the other hand, achieved his target behavior objectives in April 2017, however, his objectives were not revised.

8-9. Individual #50 and Individual #51 were not making expected progress, and their progress notes indicated that staff would be

retrained. Individual #46's progress note indicated he also was not making progress, however, it did not include actions to address the absence of progress.

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.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
17	There was a PBSP summary for float staff.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										

Comments:
16. None of the individuals had documentation that at least 80% of direct support professionals (called PNAs at Rio Grande SC) working in their residence were trained on their PBSPs. Across the individuals, the percentage of staff who were trained ranged from 30% to 48%. Ensuring that all staff assigned to work with an individual have been trained on the implementation of the PBSP should be a priority of the facility.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.

Summary: Rio Grande SC improved in the review of behavioral programming by behavioral health services staff. As a result, indicator 19 scoring showed an increase for all but one individual. Further efforts of the behavioral health services staff were evidenced by there being useful graphic summaries of data and the presentation of these graphic summaries (though much work was needed to improve the reliability of the data that are collected and summarized). Rio Grande SC was not holding peer review meetings that met the intent (and requirements) for this type of review. These five indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
19	The individual's progress note comments on the progress of the individual.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1
20	The graphs are useful for making data based treatment decisions.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were	100%	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	presented and reviewed to make treatment decisions.	1/1									
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. Individual #53 did not have a progress note because her PBSP was recently implemented. All eight of the remaining individuals had timely progress notes that described individual progress. Individual #97's progress note, however, did not accurately describe his progress.

20. All progress notes had graphs that encouraged data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. This represents an improvement from the last review when 50% of the graphs were rated as useful for making data based decisions.

21. In order to score this indicator, the Monitoring Team observed Individual #142's psychiatric clinic meeting. Recent data were available and used to make data based clinical decisions.

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 solely 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: Much attention needs to be paid to the data collection system for target behaviors and for replacement behaviors. The current system competes with the ability of staff to easily, correctly, accurately, and reliably record data (as noted in	Individuals:

many places in this report). The Monitoring Team provided feedback and suggestions for improvement during the onsite review, at the exit presentation, and in the comments below. These indicators will remain in active monitoring.

Accurate, reliable data collection is essential if progress is to be determined. IDTs utilize this information to make treatment decisions. At Rio Grande SC, for example, the psychiatrist depends upon these data to make treatment and medication decisions.

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9	0/1	0/1	0/1	0/1	0/1	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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
26-27. The data collection system for measuring undesired (target) behaviors consisted of staff recording target behaviors when they occurred. This system, which requires the PNA to request a data card from another staff person, record the behavior, and file the card in a bin, was very time consuming and complex. Additionally, the recording of target behaviors was a different system than the recording of replacement behavior data. Two PNAs interviewed by the Monitoring Team described two different processes to record and file data. Finally, the current data collection system did not allow behavioral health staff to evaluate if data were recorded in a timely manner. Because of the complexity of the system, relatively high staff effort, and inability to assess timely recording of target behaviors, it likely that this data system would result in underreported and inaccurate data.

It is suggested that the data system for the collection of target behaviors be redesigned as follows:

- 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).
- 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.
- Attempts should be made reduce the effort for staff to record accurate data. Some suggestions include:
    - Develop an individualized data card with each individual's target behaviors (currently the cards are blank/generic

cards used for all individuals for all behaviors).
- Making data cards more accessible to staff.
- Combine the target behaviors data card with the replacement behavior recording system.
- Consider a mobile system so that individualized PBSP and replacement behavior data cards could be carried by staff.

The development of a simple and sensitive data collection system needs to be a priority for the facility.

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 IOA or data collection timeliness measures of their PBSP data in the last six months. Additionally, Individual #142, Individual #114, Individual #46, Individual #22, and Individual #53 did not have documentation of any treatment integrity measures. Individual #51, Individual #103, Individual #50, and Individual #97 did have multiple treatment integrity measures, however, the scores were consistently low indicating that their PBSPs were not implemented with integrity. For example, Individual #97's PBSP data had 11 treatment integrity assessments from April 2017 to October 2017, with none above 50%. On the positive, however, it was good that the Center reported on the lack of IOA, rather than reporting inaccurate treatment integrity results.

It is critical that Rio SC ensure that PBSP data are reliable, and that PBSPs are implemented with integrity. In order to achieve this the facility needs to:
- Establish a sensitive data collection system (indicators 26 and 27).
- Demonstrate that it is producing reliable data by consistently assessing (and retraining as necessary) IOA and data collection timeliness (indicators 5, 28, 29, and 30).
- Demonstrate that the PBSPs are implemented as written by ensuring that all staff implementing the PBSPs are trained (indicator 16), and consistently assessing (and retraining as necessary) treatment integrity (indicators #28, 29, and 30).

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 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.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 3/18	1/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2

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	0/2	0/2	0/2	0/2	0/2	1/2	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 #114 – diabetes, and other: osteoarthritis of the knees; Individual #51 – osteoporosis, and other: pituitary macroadenoma; Individual #124 – respiratory compromise, and GI problems; Individual #144 – diabetes, and other: renal disease; Individual #3 – cardiac disease, and seizures; Individual #74 – cardiac disease, and osteoporosis; Individual #143 – other: bilateral renal calculi, and other: hypothermia; Individual #36 – cardiac disease, and constipation/bowel obstruction; and Individual #129– diabetes, and other: hypothyroidism).

The goals/objectives that were clinically relevant from a medical perspective, but were not measurable were for Individual #114 (i.e., control of knee pain, but the goal did not have a way to measure the individual's pain or "worsening" symptoms), Individual #74 (i.e., increased activity to address osteoporosis, but "increased" was not defined), and Individual #129(i.e., weight loss would help manage diabetes, but "through diet" was not defined, for example, reduction in snacks, decreased consumption of sugary drinks, etc.).

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #36 – constipation/bowel obstruction.

c. through e. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports on these goals with data and analysis of the data often were not available to IDTs. 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. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators at least until 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. It was good to see that the PCP completed thorough risk reviews for individuals at risk due to the use of benzodiazepines, anticholinergics, and polypharmacy, and/or with metabolic as well as endocrine risks. However, problems continued to be noted	Individuals:

with regard to how metabolic risk was calculated. These indicators will remain in active oversight.											
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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	71% 5/7	1/1	0/1	1/1	0/1	1/1	1/1	1/1	N/A	N/A
	iii. Breast cancer screening	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
	iv. Vision screen	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
	vi. Osteoporosis	63% 5/8	1/1	0/1	0/1	0/1	1/1	1/1	1/1	N/A	1/1
	vii. Cervical cancer screening	33% 1/3	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	1/1
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments: a. The following problems were noted:

- A gynecologist completed a well-woman exam for Individual #114, but it did not include a pap smear. There was no evidence of cervical cancer screening in the past, and justification for not completing a pap smear was not documented.
- Individual #51 did not have a DEXA scan, despite longstanding hyperprolactinemia. With regard to his colorectal cancer screening, in 2012, he had a colonoscopy that showed two polyps. He needed a follow-up in five years. On 11/11/16, there was an attempt to complete a colonoscopy. The pre-op diagnoses were "possible colon ulcers, colon polyps, colon arteriovenous malformations, colon cancer." The study could not be done due to poor preparation, and the recommendation was to repeat. No further attempts were documented.
- For Individual #124, the PCP identified risks related to osteoporosis, but indicated a DEXA scan was not applicable.
- Individual #144 had a DEXA scan and colonoscopy "pending."
- For Individual #36:
  - It was unclear when she had her last eye exam.
  - In 2014, her hearing was noted to be clinically normal, but the recommendation was to follow up in one year. No

follow-up was found.

- In 2012, Individual #36 had a gynecological exam under general anesthesia. The results of the cervical cancer screening were not submitted, and it was not clear when follow-up should have occurred.

b. It was good to see that the PCP completed thorough risk reviews for individuals at risk due to the use of benzodiazepines, anticholinergics, and polypharmacy, and/or with metabolic as well as endocrine risks. However, problems continued to be noted with regard to how metabolic risk was calculated (e.g., Individual #114, Individual #51, Individual #144, Individual #3, Individual #143, and Individual #129). The issues related to metabolic syndrome risk are discussed further below in relation to Outcome #8.

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: The Monitoring Team will continue to review this indicator.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									

Comments: a. According to documentation the Center provided, none of the individuals at Rio Grande State Center had DNR Orders in place.

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

Summary: Some positives were noted with regard to the Center's handling of acute events requiring transfers to an ED or a hospitalization, including that for individuals reviewed: 1) Center staff provided timely treatment and/or interventions for the acute illness requiring out-of-home care; and 2) for events that occurred during business hours, the PCPs completed timely evaluations, and for others, the PCPs wrote IPNs with summaries of events leading up to the acute events and the dispositions. However, problems continued to be noted with regard to the quality of PCPs' assessment of acute issues, as well as their follow-up to acute illnesses and occurrences. In addition, IDTs need to focus on holding post-hospital ISPA meetings to addresses follow-up medical and healthcare supports to reduce risks and promote early recognition, as appropriate. The Monitoring Team will continue to review the remaining indicators.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	If the individual experiences an acute medical issue that is addressed	22%	1/2	0/1	1/1	N/A	N/A	0/1	0/1	0/1	0/2

	at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	2/9									
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.	11% 1/9	1/2	0/1	0/1			0/1	0/1	0/1	0/2
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.	100% 4/4	1/1	N/A	N/A	1/1	N/A	N/A	2/2	N/A	N/A
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	N/A			N/A			1/2		
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	100% 4/4	1/1			1/1			2/2		
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	33% 1/3	1/1			0/1			0/1		
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	25% 1/4	0/1			0/1			1/2		

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including: Individual #114 [urinary tract infection (UTI) on 8/24/17, and fall on 9/1/17], Individual #51 (UTI on 4/24/17), Individual #124 (cough and congestion on 8/24/17), Individual #74 (multiple seizures during review period), Individual #143 (status epilepticus on 10/26/17), Individual #36 (falls on 6/20/17), and Individual #129(fracture of right 5th finger distal phalanx/subungual hematoma, and seizures on 7/11/17).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #114 (fall on 9/1/17), and Individual #124 (cough and congestion on 8/24/17).

b. For Individual #114's fall, 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.

The following provide examples of concerns noted:

- On 8/8/17, the medical clinic nurse documented that the Individual #114 was placed on the medical concerns list for "complaints of some burning on urination with slight foul odor." The nurse documented that the Physician's Assistant (PA) was notified of the complaints and responded: "client has pending cath [catheter] UA [urinalysis] on 8/24/17 as was ordered by" the PCP. Nursing staff documented that there were no new orders and the "clinic will follow up as per results if needed."

  On 9/1/17, the PCP examined the individual for a trip and fall and noted that the UA results were returned. The individual was treated in July, prior to her admission, for an extended spectrum beta lactamase (ESBL) E. coli infection. The August UA was positive for white blood cells (WBCs) and a culture was pending. Intramuscular (IM) Rocephin was prescribed with a repeat culture scheduled for 9/11/17. The PCP did not document the results of the post-treatment urinalysis. On 9/7/17, the Clinic nurse added an addendum documenting that on 9/6/17, the PCP reviewed the lab results and the diagnosis was recurrent UTI.

  In summary, on 8/8/17, Individual #114 complained of burning upon urination and was referred to the medical clinic. The PCP did not see her, nor was a urinalysis done. A urinalysis was previously scheduled for 8/24/17, over two weeks later. It is not clear why this individual with complaints of dysuria and a recent significant infection was not evaluated.
- On 3/31/17, Individual #51 was hospitalized for a UTI. On 4/24/17, the PCP ordered a urinalysis as part of the post hospital records review. At 5:40 p.m., nursing staff notified the PA of the abnormal UA results. Staff were informed that the PCP would address the issue the next day. Several hours later, nursing staff documented that the individual's urine "smells strong and fishy," but no complaints were documented.

  On 4/25/17, the PCP documented that the individual had a partially treated UTI (hospitalized from 3/31/17 to 4/12/17). The plan was to administer IM Rocephin followed by oral Keflex. The IPN notes, dated 4/24/17 and 4/25/17, appeared to be reviews of hospital data and follow-up labs. There was no evidence that a medical provider assessed the individual to determine if there were any signs or symptoms of a UTI. Moreover, there was no PCP follow-up for this issue or documentation in the PCP's IPNs that the infection resolved.
- On 8/24/17, the PA saw Individual #124 due to complaints of coughing and congestion that started on 8/23/17. The physical exam was pertinent for pharyngeal erythema, rhonchi, and wheezing on the pulmonary exam. The assessment was cough/congestion and pharyngitis. It should be noted that cough and congestion are symptoms and not a diagnosis. Based on the documentation of the physical exam, the individual had evidence of a lower respiratory tract infection (LRI).

  The plan was to obtain a stat chest x-ray, a complete blood count (CBC), rapid strep screen, and flu nasal swab. An albuterol metered-dose inhaler also was ordered. The plan also documented that: "Tylenol 650mg PO [by mouth] q6h [every six hours] prn [pro re nata, or "as needed"] x 72 hours only if temperature goes above 100.3F [Fahrenheit]." The PA provided no parameters related to this order and no requirement that nursing notify the PCP for elevated temperatures. As written, it would appear that nursing staff could administer Tylenol for a significantly elevated temperature without notification of a

physician.

On 8/25/17, the PCP documented that the chest x-ray showed no acute findings (i.e., stable fibrotic changes consistent with tuberculosis). On 8/28/17, the PA noted that the CBC was within normal limits, and the flu and strep tests were negative. It was documented that the "client has not allowed any follow-up examination at this time but is asymptomatic at this time." On 9/29/17, the PCP completed an interim medical review (i.e., chart review), and on 10/4/17, the on-call PCP wrote an IPN related to the Hanger Clinic consult. However, there was no additional documentation or follow-up in the records related to the acute illness.

- Based on the Monitoring Team's review of Individual #74's records, he had seven seizures in the six months prior to the review. Each time, the nurse wrote a note that included the anti-epileptic drugs (AEDs) and the last blood levels. However, no documentation was found of a PCP assessment related to this increase in seizure frequency. The nurses did not appear to notify the PCP of the seizures.
- On 8/2/17, the neurologist saw Individual #143, and noted his seizures were well controlled with the last seizure documented on 3/31/17. During a September 2017 hospitalization, the hospital neurologist recommended referral to his regular neurologist due to abnormal electroencephalogram (EEG) findings. On 10/19/17, the PCP adjusted the AEDs without neurology consultation and the seizure frequency increased.

  On 10/26/17, nursing staff documented that a seizure had been occurring for four minutes when the PA was contacted and ordered 1 milligram (mg) Ativan IM stat. When the PA assessed the individual, it was noted that mild tonic clonic activity was occurring. It also was noted that the "client's signs quickly resolved within a minute or so," after the administration of the IM Ativan. Based on this documentation, the individual had tonic clonic seizure activity for at least five minutes, which meets the criteria for status epilepticus. The documentation also clearly noted that when nursing staff contacted the PA, the seizure had been occurring for at least four minutes. Status epilepticus is a neurologic emergency that requires prompt evaluation and treatment. The management of this individual was not consistent with State Office guidelines for management of status epilepticus.
- On 7/5/17, the psychiatrist documented in the IPN a plan to decrease Individual #129'sTegretol followed by Klonopin. The psychiatrist documented that this was discussed with the PCP and the PA, and there were no concerns.

  On 7/11/17, the PCP noted that four seizures were documented that day and a total of six within the last 24 hours, and that no medication changes were made since April 2017. It was not clear that this was accurate, given the psychiatry note on 7/5/17. The plan was to check labs and provide hydration. The assessment of skin turgor appeared to be the sole basis of the diagnosis of dehydration. The blood pressure was normal, and no orthostatic measurements were taken.

  On 7/11/17, the psychiatrist reiterated that the increased seizures were due to dehydration and not medication tapering. However, there was no physical assessment to support this statement. On 7/11/17, it was documented that the chemistries were all normal.

  The PCP never completed and/or documented any follow-up to assess the status of hydration. The physical exam, vital signs, and lab data did not support the diagnosis of dehydration.

c. For three of the nine individuals reviewed, the Monitoring Team reviewed four acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #114 (laceration on 10/10/17), Individual #144 (finger dislocation and avulsion fracture on 10/23/17), and Individual #143 (hypercalcemia/hypernatremia on 9/12/17, and dehydration, hypothermia, and urinary tract infection on 9/28/17).

It was good to see that for the two acute events that occurred during business hours, the PCPs completed timely evaluations, and for the two that occurred after hours, within one business day, the PCP wrote an IPN with a summary of events leading up to the acute event and the disposition.

e. It was good to see that prior to their transfers, all three individuals received timely treatment and/or interventions for the acute illness requiring out-of-home care.

d., f., and g. The following provide examples of the findings for these four acute events:

- On 10/10/17 at approximately 4:40 p.m., the PCP saw Individual #114 due to a forehead laceration. The laceration was cleaned and closed with Dermabond. On 10/11/17, a nurse wrote a late entry describing a series of events starting with the initial injury on 10/10/17. It also noted that around 8:16 p.m. on 10/10/17, Individual #114 was transferred to the ED due to bleeding of the wound and enlargement of the hematoma. The individual was evaluated in the ED. A computed tomography (CT) of the head was negative for intracranial bleeding. The laceration was re-closed with Dermabond and Steri strips. On 10/11/17, another nurse wrote a note documenting that the individual arrived from the hospital at 12:53 a.m. On 10/11/17, the PCP saw Individual #114. Follow-up should have occurred again on 10/12/17, but no documentation was submitted to show it did, and there was no follow-up documented to show that the laceration had healed.
- On 10/23/17, Individual #144 dislocated his finger during a fall. He was transferred to the ED, where he was diagnosed with a dislocation of the left 3rd finger. The dislocation was reduced, finger splinted, and the individual returned to the Center. On 10/24/17, the PCP evaluated the individual and referred him to orthopedics for follow-up. The PCP did not conduct and/or document a follow-up assessment. On 10/27/17, the PCP made an IPN entry for the orthopedic consult. The diagnosis was left 3rd finger proximal interphalangeal (PIP) dislocation with volar condyle avulsion fracture. The IDT should have held an ISPA meeting to discuss the supports needed to ensure the individual's compliance with the keeping his finger immobilized.
- On 9/11/17, the PCP documented that Individual #143 had an acute onset of lower extremity weakness. The PCP noted that due to recent falls and altercations, x-rays and labs would be checked. The plan was to proceed to brain imaging if the initial studies were negative. On 9/12/17, the PCP documented the results of the x-rays. The IPN clearly noted that this was a summary review. There was no documentation that the individual was assessed again or examined. The series of x-rays was negative. A second IPN note documented lab results noting that on 9/11/17, the individual's sodium level was 153, and on 9/12/17, the repeat was 155 with a calcium of 10.7. The individual was referred to the ED for evaluation. This note did not include any documentation of a physical exam or vital signs. On 9/11/17, the initial exam included a physical examination that focused on the range-of-motion (ROM) of Individual #143's extremities and a neurological assessment. However, the subsequent note did not document any examination that would be necessary to determine if the physical findings had progressed or improved.

On 9/12/17, Individual #143 was admitted to the intensive care unit (ICU) with metabolic derangements, including hyponatremia and hypothermia. He was obtunded and hemodynamically unstable requiring short-term Levophed and midodrine to maintain adequate blood pressure. His diagnoses were sepsis/UTI, hypotension, hyponatremia, and hypothermia.

On 9/19/17, the individual returned to the Center, and the PCP evaluated him. The PCP noted that the hypothermia had resolved and would be monitored. The PA also documented that the last seizure was on 3/31/17, and the hospital neurologist recommend that the individual's regular neurologist see him due to abnormal EEG findings. The plan was to await the recommendation of the neurologist before making any changes in the AEDs. The final line of the IPN entry was: "will follow-up on client's lab work as it becomes available and follow-up with client as needed." However, the PCP did not document follow-up or lab work. This individual required admission to the ICU and a pressor for blood pressure support, but the PCP saw him only once following discharge from the hospital. The next assessment was on 9/28/17 by the covering PCP.

On 9/25/17, the IDT held an ISPA meeting, but the medical staff did not attend. This individual was critically ill upon admission and was admitted into the ICU. The IDT should have discussed if Center supports prior to the admission met his needs, and a member of the medical staff (PCP/PA) was needed to conduct such a review.

- On a positive note, for Individual #143's hospitalization for dehydration, hypothermia, and urinary tract infection on 9/28/17, the Center met the criteria for all of the indicators. More specifically, the covering PCP noted that the individual was seen to assess the level of consciousness and clinical status. The covering PCP documented that the labs drawn on 9/25/17 were concerning due to an increase in the blood urea nitrogen (BUN)/creatinine ratio. The individual was noted to be hypotensive with a blood pressure of 90/60 and labs were drawn. An addendum documented: "On the afternoon of 9/28/17 received the results of the lab work that I had ordered on [Individual #143], a patient at ICF who was not looking too well to me today." The Bun/creatinine ratio was reported at 58 (it was 28 at discharge and 48 on 9/25/17). The decision was made to transfer the individual to the ED, where he was admitted. The discharge diagnoses were dehydration, hypernatremia, UTI, anemia, and hypothyroidism. The individual also underwent placement of a percutaneous endoscopic gastrostomy (PEG) tube.

  On 10/3/17, Individual #143 returned to the Center and the covering PCP (i.e., the one who did the hospital referral) completed a post-hospital assessment. The assessment summarized the hospital course, the discussion with the attending MD about the persistent hypothermia, and described a physical exam and a plan of care. This was a thorough assessment. This PCP documented daily exams and a plan of care over a period of several days, with the last being 10/13/17 (Friday).

  As an epilogue, on 10/15/17, Individual #143 was seen in the ED for a dislodged PEG-tube. On 10/16/17, the regular PCP documented an assessment. This assessment covered the events of the previous weeks, and also noted that the hypothermia was "considered to be adverse drug reaction orders dated 10/03/17." It was notable that no ADR form was submitted. On 10/17/17, labs were documented. On 10/19/17, the PCP made the decision to make a change in the AEDs based on the hypothermia. On 10/20/17, the PCP noted that: "He is on 1/2 the Keppra dose starting on 10/19/17 and noted slight increase in seizures and improved rectal temperature." On 10/23/17, the PCP documented "expected seizure activity due to changes in medication." On 10/26/17, the PCP documented that the hypothermia had resolved and additional changes to medications were made to improve seizure control. The changes in seizure medication were made without consulting the neurologist (it

was noted in the 9/19/17 discharge assessment that the hospital neurologist made this recommendation). As discussed in more detail above, on 10/26/17, there was documentation consistent with an episode of status epilepticus.

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

Summary: For this review and the last one, PCPs generally indicated agreement or disagreement with consultation recommendations, did so in a timely manner, and often wrote an IPN that included the necessary components. If the Center sustains this performance, then after the next review, Indicators a, b, and c might move to the category requiring less oversight. Given that over the last two review periods and during this review, for the consultations reviewed, when PCPs agreed with consultation recommendations, evidence was generally found to show PCPs ordered the recommendations (Round 10 – 100%, Round 11 – 88%, and Round 12 – 94%), Indicator d will move to the category requiring less oversight. The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 16/16	2/2	2/2	2/2	2/2	2/2	2/2	2/2	N/A	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	100% 16/16	2/2	2/2	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.	88% 14/16	2/2	2/2	0/2	2/2	2/2	2/2	2/2		2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	94% 15/16	1/2	2/2	2/2	2/2	2/2	2/2	2/2		2/2
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	33% 2/6	0/1	N/A	0/1	0/2	2/2	N/A	N/A		N/A

Comments: For eight of the nine individuals reviewed, the Monitoring Team reviewed a total of 16 consultations. The consultations reviewed included those for Individual #114 for cardiology on 9/20/17, and ear, nose, and throat (ENT) on 9/7/17; Individual #51 for pulmonology on 7/11/17, and endocrinology on 8/24/17; Individual #124 for pulmonology on 7/26/17, and ENT on 4/10/17; Individual #144 for nephrology on 9/15/17, and nephrology on 7/21/17; Individual #3 for ENT on 9/8/17, and neurosurgery on 9/12/17; Individual #74 for neurology on 8/8/17, and neurology on 5/10/17; Individual #143 for urology on 9/5/17, and neurology

on 8/2/17; and Individual #129for neurology on 9/21/17, and orthopedics on 4/24/17.

a. and b. It was positive that PCPs reviewed the consultation reports reviewed, indicated agreement or disagreement with the recommendations, and did so in a timely manner.

c. Most of the PCP IPNs related to the consultations reviewed included all of the components that State Office policy requires. The exceptions were for Individual #124 for pulmonology on 7/26/17, and ENT on 4/10/17, which did not state whether or not there was a need for referral to the IDT.

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 exception of the following: on 9/20/17, the cardiologist recommended that Individual #114's Lasix continue at 20 to 40 mg daily, that an echo be obtained in six months to evaluate known diastolic congestive heart failure, and that periodic electrolyte checks be completed. The PCP agreed to implement the recommendations, but no order was found related to the Lasix recommendation, and the medication profile did not show that it was prescribed.

e. It was good to see that the PCP made referrals to Individual #3's IDT, and the IDT met to discuss the need for a hearing aid evaluation, and upcoming spine surgery and the need for post-operative supports. The following provide examples, though, of where referral to the IDT did not occur, but would have been important:

- Individual #144 had significant loss of renal function. The consultant gave specific recommendations, such as the avoidance of nonsteroidal anti-inflammatory drugs (NSAIDs) and nephrotoxic drugs, preservation of the non-dominant arm (this is for use in hemodialysis), and a low protein diet. Symptoms of uremia were explained. This information was not fully summarized in the IPN and the consult was not referred to the IDT. It is important that the IDT be aware of the precautions for an individual with significant loss of kidney function. For example, on 10/25/17, nursing staff documented that ibuprofen (i.e., an NSAID) was administered as prescribed by a covering physician.
- Individual #124 was diagnosed with moderate hearing loss, but this was not referred to the IDT to ensure proper supports were in place.
- Similarly, for Individual #114, a new diagnosis of mild sensorineural hearing loss was established, but this information was not referred to the IDT to ensure that supports were in place.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Summary: Work is needed to ensure that for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCP identifies the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	Individual with chronic condition or individual who is at high or	50%	1/2	0/2	2/2	1/2	0/2	1/2	1/2	2/2	1/2

	medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	9/18									

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #114 – diabetes, and other: osteoarthritis of the knees; Individual #51 – osteoporosis, and other: pituitary macroadenoma; Individual #124 – respiratory compromise, and GI problems; Individual #144 – diabetes, and other: renal disease; Individual #3 – cardiac disease, and seizures; Individual #74 – cardiac disease, and osteoporosis; Individual #143 – other: bilateral renal calculi, and other: hypothermia; Individual #36 – cardiac disease, and constipation/bowel obstruction; and Individual #129– diabetes, and other: hypothyroidism).

a. For the following individuals' chronic or at-risk conditions, it was good to see that 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: Individual #114 – other: osteoarthritis of the knees; Individual #124 – respiratory compromise, and GI problems; Individual #144 – other: renal disease; Individual #74 – osteoporosis; Individual #143 – other: hypothermia; Individual #36 – cardiac disease, and constipation/bowel obstruction; and Individual #129– other: hypothyroidism). The following provides examples of concerns noted:

- The risk section of Individual #114's AMA indicated she was at low risk for metabolic syndrome, even though she had two risk factors (i.e., an abdominal girth of 36 inches, and she was treated for hypertension). However, she also had an A1c of 5.2 (i.e., 8/9/17), and was treated with a second-generation antipsychotic, which increases the risk of hyperglycemia and hyperlipidemia. Acknowledging that the individual had a medium or high risk would/should have resulted in increased surveillance and interventions, such as psychiatry's consideration of the use another psychotropic or keeping it at the lowest possible dose, consideration of repeating the A1c more frequently since the risk is increased, etc. On a positive note, a weight loss program was discussed in the AMA plan.
- Similarly, Individual #129's AMA noted that the individual did not have diabetes or meet any criteria for metabolic syndrome. Therefore, she was rated at low risk. This assessment was not accurate. More specifically, pravastatin was listed as a current medication, and the individual's abdominal girth was 89 centimeters (35 inches). In addition to meeting two of three criteria for metabolic syndrome, the individual was treated with a second-generation antipsychotic, which increases risk.
- Neither Individual #51's AMA or IHCP addressed significant issues related to long standing hyperprolactinemia and the pituitary macroadenoma, including the potential for visual disturbances, galactorrhea, and osteoporosis. In fact, the ophthalmology consult form only stated that the individual needed an annual eye exam. Neither the PCP nor the consultant documented the diagnosis of a pituitary macroadenoma on the form. Monitoring for visual impairment (vision loss/double vision) and headaches is an important aspect of surveillance for individuals with a pituitary macroadenoma. This should have been addressed in the ophthalmology consult.

  Another concern was a lack of discussion with psychiatry regarding the use of risperidone. The continued use of risperidone increased the likelihood of failure to respond to treatment with the first-line agent of cabergoline.
- As noted above, Individual #51 had long term and significant hyperprolactinemia, which increases the risk for osteoporosis. Per the AMA, he was also wheelchair dependent due to contractures. The PCP assessed a medium risk for osteoporosis, but documented that the individual had "no criteria to necessitate a DEXA."
- According to Individual #144's AMA, a hospital discharge summary on 7/22/16, noted a diagnosis of Type 2 diabetes mellitus (T2DM). Another document noted an A1c of 5.7. The PCP went on to state that this was most likely a documentation error.

Therefore, the individual was assigned a low risk rating. However, glucose levels assessed at RG State Center had been intermittently elevated, and on 10/3/17, the A1c was 5.7. Additionally, the AMA stated that based on the admission labs done on 11/26/16, the individual "meets 3 out of 5 metabolic risk factors: Abdominal Girth M [male]>102, Triglycerides >150, BP [blood pressure] 130/85." The PCP had clearly stated that the individual met criteria for metabolic syndrome, but assigned a low risk rating for metabolic syndrome/diabetes.

- According to Individual #3's AMA, he was rated at high risk due to hyperlipidemia treated with Crestor. He also had a prolonged QT interval on the 12/31/16 electrocardiogram (EKG). This was believed to be due to the psychotropic medications. The plan in the AMA for the increased QT interval was to refer the individual to psychiatry and monitor EKGs every six months, unless psychiatry specified otherwise. The interim medical review, dated 10/26/17, indicated the last EKG was completed in December 2016. The AMA plan for the hyperlipidemia was to refer the individual to nutrition for a low-fat diet and to check lipids every three months.

  As noted above, Individual #3 was treated with a statin. On 4/6/17, the PCP noted that the atherosclerotic cardiovascular disease (ASCVD) risk score was 7% (while receiving statin therapy), and, therefore, statins were not indicated. The plan was to discontinue the statin and recheck the lipids in three months. On 7/7/17, the PCP documented that the ASCVD risk score was now 7.9%, and a statin would be re-started and lipids rechecked in three months. Current guidelines do not require that lipids be rechecked in three months. It is expected that the lipids would decrease if the individual were compliant with medical therapy. Lipids are followed to ensure compliance, but are not required to guide therapy. A general precept for most individuals is to continue primary prevention strategies and not discontinue them if they are well tolerated.

  The American Heart Association has identified four groups most likely to benefit from statin therapy:
  - Patients who have cardiovascular disease (CV);
  - Patients with low-density lipoprotein (LDL) cholesterol of 190 or higher;
  - Patients with T2DM who are between 40 and 75; and
  - Patients with an estimated 10-year risk of CV disease of 7.5% or higher who are between 40 and 75 years of age.

  For individuals who do not fall into one of the four statin benefit groups, other factors may be considered when making treatment decisions. Providers should fully review the American College of Cardiology/American Heart Association (ACC/AHA) statements and treatment guidelines on assessment of ASCVD risk and statin therapy.
- Similarly, Individual #74's interim medical review, dated 3/28/17, noted that he was treated with a statin for hyperlipidemia. The ASCVD risk score calculated while on statin therapy was not high enough to warrant statin therapy. Therefore, the statin was discontinued. According to the risk section of the AMA, dated 9/27/17, the lipid panel done on 6/5/17, resulted in an ASCVD risk score of 7.7% with an indication for moderate to high intensity statin use. The individual was started on atorvastin, and on 9/5/17, the lipid panel was rechecked. The corresponding risk score was 3.3%. The plan was to recheck lipid panel and recalculate the risk score every three months to monitor temporal stability. This is not the correct application of the ASCVD risk score. Again, it is expected that lipids would improve with statin therapy and the risk score would decrease.
- Per Individual #3's AMA, the PCP was tapering Dilantin down "in the hopes of discontinuing it altogether and [he would] remain on monotherapy of Keppra." A psychiatry note, dated 7/11/17, documented that neurology consults were done on 6/13/16, and 12/13/16, and the recommendation each time was to continue Keppra and Dilantin. It was unclear why the PCP

made the decision to taper the Dilantin without neurology consultation, given the recommendations to continue current medications.

- Per Individual #143's AMA, on 7/2/15, a CT scan of the abdomen and pelvis showed bilateral renal calculi. The urinalysis noted calcium oxalate crystals. The AMA further documented that the individual was on topiramate, which causes calcium phosphate stones. The package insert for Topamax provides specific warnings and precautions related to the development of kidney stones.

  The neurology consult, dated 5/1/17, did not include the diagnosis of bilateral renal calculi, so it was not clear that the neurologist was aware of this diagnosis. The consult request form for the 8/2/17 consult included a note "has PMHx [previous medical history of] bilateral renal stones and osteoporosis." The neurologist did not include renal calculi in the PMH section of consult. There was no direct question posed to the neurologist regarding the risks and benefits of continued use of topiramate in an individual with documented renal calculi.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	39% 7/18	1/2	0/2	2/2	0/2	0/2	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. In addition, those action steps assigned to the PCPs that were identified for the individuals reviewed often were not 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/A			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	If the individual has new medications, the pharmacy completes a new	N/R									

	order review prior to dispensing the medication; and										
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. In response to the Monitoring Team's request (#55) for information about new orders, the Center indicated "not available." By March 1, 2018, the Center should submit to the Monitoring Team a list of documents it could product to show compliance with these indicators.											

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: In comparison to the last two reviews, significant improvement was seen with the timely completion of QDRRs (Round 10 – 44%, Round 11 – 22%, and Round 12 - 88%). Improvement is needed with regard to the quality of the QDRRs, particularly the review of laboratory results, and new generation antipsychotic use, as well as the inclusion of recommendations, as appropriate.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	QDRRs are completed quarterly by the pharmacist.	88% 15/17	1/1	2/2	2/2	2/2	2/2	2/2	0/2	2/2	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;	24% 4/17	0/1	0/2	0/2	0/2	2/2	2/2	0/2	0/2	0/2
	ii. Benzodiazepine use;	100% 17/17	1/1	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 17/17	1/1	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	73% 8/11	1/1	1/2	2/2	2/2	2/2	N/A	N/A	N/A	0/2
	v. Anticholinergic burden.	100% 17/17	1/1	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner										

	depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
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. For most QDRRs reviewed, the Clinical Pharmacist had not conducted a thorough review of labs, and/or made recommendations to address concerns related to lab monitoring. The following provide examples:

- For Individual #114, the Clinical Pharmacist made no comments on the hyponatremia that was attributed to the divalproex and no ADR information was submitted. Additionally, the Clinical Pharmacist documented the cardiology consult, dated 9/20/17, that recommended the continuation of furosemide, but did not make a comment related to this consultation. However, based on the medication list submitted, the individual was not receiving furosemide.
- Individual #51 had severe hyperprolactinemia that was attributed to a macroadenoma and use of risperidone. The Clinical Pharmacist noted that the prolactin was elevated, but made no comment on how the use of risperidone impacted treatment of hyperprolactemia. Individual #51 failed to respond to first-line therapy with carbergoline.
- Individual #124 was treated with ferrous sulfate for iron deficiency anemia. Although his ferritin level remained low, the Clinical Pharmacist made no comments.
- For Individual #144, the QDRR included no discussion of worsening kidney disease nor was there a glomerular filtration rate (GFR) calculated for this individual with a creatinine of 2. Clinical pharmacists play a significant role in the management of chronic kidney disease (CKD). Medication selection, medication dosages, and monitoring for toxicity and ADRs are important issues for individuals with CKD. The active problem section of the QDRR did not cite this as a problem.
- For Individual #143, the Clinical Pharmacist documented that the Topiramate dose was increased to improve seizure control. There were several issues related to the use of Topiramate that the Clinical Pharmacist did not discuss:
    - Of significant concern, there was no discussion about the use of Topiramate (and increasing the dose) in an individual with renal calculi.
    - There also was no discussion related to the persistent hypothermia that was noted in September 2017.
    - There was no discussion of the low and low normal serum bicarbonate levels that were likely a result of a metabolic acidosis, which is associated with Topiramate use and increases the risk of stone formation and stone growth.

With regard to new generation antipsychotic use, for Individual #129, the Clinical Pharmacist did not assign a risk level and answered "no" to the question of "Is the patient at risk for metabolic syndrome?" There also was no recommendation to obtain an A1c, even though there were several elevations (>100) of blood glucose documented in the record.

d. For the one individual for whom the Clinical Pharmacist made a recommendation and the PCP agreed with it, documentation was presented to show the PCP responded to the recommendation. As noted above, though, the Clinical Pharmacist missed multiple

opportunities to make recommendations.

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 did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	38% 3/8	0/1	1/1	0/1	0/1	1/1	0/1	N/A	0/1	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/8	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% 0/8	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% 0/8	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% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments: a. and b. Individual #143 was edentulous, but was part of the core group, so a full review was conducted. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. Based on information included in their IRRFs and IHCPs, three individuals had clinically relevant goals/objectives related to dental. For the remaining individuals, the IRRFs did not include sufficient rationale to show that the proposed goals/objectives addressed the underlying cause(s) or etiology(ies) of the individuals' dental issues. It was positive that the dental hygienist made recommendations related to the dental goals/objectives, but other IDT members, particularly direct support professionals, behavioral health services staff, and nurses, need to contribute information, including whenever possible, specific data to substantiate that the proposed goals/objectives meets the individuals' needs. For example, for tooth brushing compliance goals, residential and nursing staff should provide data about the individuals' current compliance with tooth brushing in the home. Behavioral Health Services staff should assist in identifying reinforcers that will increase the likelihood of successful implementation of the goals/objectives.

None of the goals/objectives reviewed were measurable. Often criteria for completion/success were missing (e.g., for 85% of the trials for three consecutive months).

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals with data and analysis of the data often were not available to IDTs. 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 provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: Most individuals reviewed did not have diagnosed or untreated dental caries. Except for one individual who was edentulous, all individuals reviewed had periodontal disease.

#	Indicator	Overall Score	Individuals: 114	51	124	144	3	74	143	36	129
a.	Individuals have no diagnosed or untreated dental caries.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1
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/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	50% 3/6	0/1	1/1	N/A	N/A	0/1	1/1	N/A	0/1	1/1
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: a. and b. Individual #143 was edentulous.

b. One individual reviewed was edentulous, and two individuals were newly admitted, which had not permitted serial probing, but both had periodontal disease. The remaining six individuals had periodontal disease. For some individuals reviewed (e.g., Individual #114, Individual #3, and Individual #36), because up-to-date periodontal charting or x-rays were not completed, evidence was not available to determine the status of their periodontal condition. Individual #51 and Individual #74 maintained Type III periodontal disease, and Individual #129maintained Type II periodontal disease.

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: Given that over the last two review periods and during this review, individuals reviewed generally had needed dental x-rays (Round 10 – 100%, Round 11 – 89%, and Round 12 – 100%), Indicator c will move to the category requiring

Individuals:

less oversight. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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.	50% 4/8	0/1	1/1	1/1	0/1	0/1	1/1	N/A	0/1	1/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	71% 5/7	1/1	0/1	1/1	1/1	1/1	1/1		0/1	N/A
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	63% 5/8	0/1	1/1	1/1	1/1	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.	50% 4/8	0/1	1/1	1/1	1/1	0/1	0/1		0/1	1/1
f.	If the individual has need for restorative work, it is completed in a timely manner.	100% 4/4	N/A	1/1	1/1	1/1	1/1	N/A		N/A	N/A
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A		N/A	N/A
Comments: a. through f. Individual #143 was edentulous. A number of individuals reviewed had not had one or more type of needed dental treatment.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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 provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. Based on information the Center provided, none of the individuals the Monitoring Team reviewed had experienced dental emergencies in 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: N/A			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	N/A									
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	N/A									
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	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.	N/A									
Comments: a. through d. None of the individuals reviewed required suction tooth brushing.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Improvements were needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For the individuals reviewed with missing teeth, the Dental Department often did not provide recommendations regarding dentures.											

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: It was good to see that that nursing staff timely notified the practitioner/physician of signs and symptom of an acute occurrence in accordance with the nursing guidelines for notification. 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. Nursing staff also need to improve the quality of acute care plans. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0% 0/2	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	100% 1/1	N/A	N/A		1/1	N/A		N/A		
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/5	0/1	0/1		0/1	0/1		0/1		
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/4	N/A	0/1		0/1	0/1		0/1		
e.	The individual has an acute care plan that meets his/her needs.	0% 0/5	0/1	0/1		0/1	0/1		0/1		
f.	The individual's acute care plan is implemented.	0% 0/5	0/1	0/1		0/1	0/1		0/1		
Comments: The Monitoring Team reviewed five acute illnesses and/or acute occurrences for five individuals, including Individual #114 – urinary tract infection (UTI) initiated on 9/1/17; Individual #51 – status post hospitalization for UTI/dehydration initiated on 4/12/17; Individual #144 – avulsion fracture of the base of the left middle finger initiated on 10/23/17; Individual #3 – antibiotic therapy for surgical incision initiated on 7/28/17; and Individual #143 – PEG-tube placement initiated on 10/2/17. b. This indicator was not applicable for most illnesses/occurrences reviewed (i.e., Individual #114's UTI was found when the PCP										

conducted a urinalysis, Individual #51's UTI/dehydration for which the acute care plan was developed after a hospitalization, Individual # 3's surgical incision for which an acute care plan was initiated upon his return to the Center, and Individual #143 – PEG-tube placement for which an acute care plan was initiated upon his return to the Center). The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the applicable nursing protocol was: Individual #144 – avulsion fracture of the base of the left middle finger initiated on 10/23/17.

e. Common problems with the acute care plans that were submitted included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs (exceptions were Individual #114 – UTI initiated on 9/1/17; Individual #144 – avulsion fracture of the base of the left middle finger initiated on 10/23/17, and Individual #3 – antibiotic therapy for surgical incision initiated on 7/28/17); alignment with nursing protocols (exceptions were Individual #114 – UTI initiated on 9/1/17; and Individual #144 – avulsion fracture of the base of the left middle finger initiated on 10/23/17); 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 following provide some examples of concerns noted with regard to this outcome:

- On 9/1/17, Individual #114 was diagnosed with a UTI through a urinalysis. Upon discovery, the nurse did not conduct a nursing assessment. It was positive that the acute care plan included a list of assessment criteria. However, a number of the interventions were not measurable (e.g., "encourage fluids"), and the assessments nurses described in the IPNs did not contain all of the assessment criteria listed. In addition, IPNs did not show assessments completed at the expected frequency.
- The documentation requested dated back to 4/1/17, at which time Individual #51 was in the hospital. Upon his release, nursing staff did not complete a comprehensive post-hospitalization assessment. In fact, the nursing IPNs, dated 4/12/17, indicated his nutrition was "excellent," when he just returned from a hospitalization for dehydration. Nursing staff developed an acute care plan for the UTI and dehydration. The acute care plan did not detail all of the necessary specific assessment criteria, and most of the interventions were not measurable (e.g., "encourage" rest, fluids, and voiding). The acute care plan did include some well-written interventions, including assessment of skin turgor and vital signs daily; assessment of the frequency of voiding, as well as the odor, color, and clarity of the urine; and monitoring for intake of at least 1500 milliliters per day. Not all interventions included the frequency, though. In addition, nurses had not documented daily nursing assessments in the IPNs addressing dehydration, skin turgor, fluid intake, mucous membranes, output, color of urine, odor, amount, pain, and/or frequency/urgency.
- For Individual #144's left middle finger fracture, it was good to see that nursing staff timely informed the PCP in accordance with the applicable nursing protocol. However, the nurse's initial assessment did not include assessment of pain, color of skin, temperature, range of motion of the other fingers, or an assessment for other injuries due to the fall. Similarly, when Individual #144 returned from the ED, the nurses' assessment lacked a description of the left finger/hand, swelling, bruising, a set of vital signs, and temperature of the skin. The acute care plan included a good basic assessment of vital signs, oxygen saturations, pain, edema, deformity, discoloration, and decreased range of motion to be done daily. However, not all interventions were measurable or defined the frequency of implementation. It was good to see that nurses conducted the assessments daily, but not all of the interventions were measurable (e.g., "encourage"), so it was difficult to determine whether or not all interventions were implemented.
- When Individual #3 returned to the Center, the nursing IPN indicated that he had a seven-centimeter (cm) incision to the right

side of his neck, but did not provide a description. The only assessment criteria included in the acute care plan were to assess and document at least daily for one week his vital signs, the wound size, color, approximation, and temperature. The acute care plan included no mention of drainage, odor, or the individual's tolerance of the incision site. Other interventions were not measurable, such as treat pain, initiate appropriate protocols, stress importance of wearing clean gloves, encourage handwashing, avoid periods in the sun, and advise individual that symptoms might not improve immediately, but will improve when treatment is finished. The IPNs did not document daily nursing assessments.

- On 9/28/17, Individual #143 went to the hospital for refusal to drink. Prior his transfer, the nurse did not complete a full assessment, including lung sounds, bowel sounds, fluid intake for the day, or mental status. While he was in the hospital, on 10/1/17, a PEG-tube was placed for nutrition and hydration. Upon his return, a nurse's assessment of the PEG-tube site was not found in the documentation submitted. The acute care plan included essentially no assessment criteria for the PEG-tube site, and many of the interventions were not measurable. Although the IPNs included regular assessments of Individual #143's overall status, they did not include assessments addressing the PEG-tube site.

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. However, of note, nursing staff initiated weekly meetings to address the identification and development of goals for individuals' risk areas for the Integrated Health Care Plans. This was a positive step forward and the first of its kind in any Center. The very promising meeting that members of the Monitoring Team observed included brainstorming, clinical dialogues, and a great deal of enthusiasm as the group worked together to determine the cause of the individuals' health risks to lead to the identification of measurable goals. The group correctly identified the need for additional clinical data necessary to determine the cause of the individual's health risks. Center staff are encouraged to continue these efforts. These indicators will remain in active oversight.

Individuals:

#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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	1/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	11% 2/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	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%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

		0/18									
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 #114 – constipation/bowel obstruction, and falls; Individual #51 – weight, and other: hypothyroidism; Individual #124 – skin integrity, and GI problems; Individual #144 – falls, and dental; Individual 3 – constipation/bowel obstruction, and falls; Individual #74 – dental, and choking; Individual #143 – constipation/bowel obstruction, and UTIs; Individual #36 – constipation/bowel obstruction, and falls; and Individual #129 – weight, and falls).

Individual #74's IHCP for choking included a goal/objective related to taking thin liquids throughout his meal. It was clinically relevant, but not measurable (i.e., "consistently" was not measurable, and it was unclear whether it was his intake of the liquids, or staff's compliance with offering the liquids that was to be measured). The goal also included only two trials, and the rationale for this was unclear.

Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #36 – constipation/bowel obstruction, and Individual #129 - weight.

c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, integrated progress reports with data and analysis of the data often were not available to IDTs. 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 four 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	114	51	124	144	3	74	143	36	129
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% 0/12	0/1	0/2	0/2	0/2	0/1	0/1	0/1	0/1	0/1
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 individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally 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.

The following provide some examples of risks that required IDTs to take more immediate action:

- According to the Center's data, since Individual #114's re-admission on 7/13/17, she had fallen on 7/15/17, 7/29/17, 9/1/17, 9/24/17, 10/6/17, and 10/26/17. However, the IPNs indicated that she also had been found on the floor at times, which might have been fall-related (e.g., on 10/10/17, and 10/11/17). The ISPA, dated 7/13/17 (Admission Meeting), noted that she "had stumbled while at MH [Mental Health]. Nurse advised that she is not walking right now and it may be due to weight gain." Her annual medical assessment, dated 7/13/17, noted she had degenerative joint disease of the left knee, osteoarthritis, osteoporosis, kyphosis, scoliosis, an age-related nuclear cataract, pre-glaucoma, myopia of both eyes, hearing loss, hypertension, intra-articular injections to her left knee in 2015 and 2016, ankle and leg edema, obesity, and was prescribed medications that can cause orthostatic hypotension. The Admission Nursing Assessment noted that in 2014, a consult indicated that total knee replacements would be required to control pain, but because of her "mental retardation and mental condition she is not a candidate for surgery." There was no indication that this was re-visited or re-assessed. At the time of the Monitoring Team's review, the IDT had not held ISPA meetings addressing her falls, pain, or mobility. The ISPA, dated 10/11/17, noted that the RN Case Manager reported that Individual #114 had a pro re nata (PRN, or "as needed") prescription for Tylenol for knee pain, and that she had been in pain multiple times, but nursing staff had not given her the Tylenol. Overall, there was no indication that the IDT was attempting to identify the cause(s) of her falls in order to prevent them.
- The ISPAs indicated that Individual #51's IDT was discussing issues, such as injuries, behaviors, and overall medical concerns, such as bilateral nodules in his lungs, UTI, weight, high prolactin levels, psychotropic medications, a hospitalization, and updates to his IHCP. However, the IDT had not addressed his pituitary adenoma as a specific risk area and its possible impact on some of the medical issues he had been experiencing, such as weight loss, behavioral issues, hypothyroidism, high prolactin levels, dehydration, and urinary incontinence. In addition, it did not appear that when reviewing behavioral issues, the IDT considered the possible symptoms of anxiety, depression, and/or pain/headaches. The ISPA, dated 4/17/17, noted that the dietician indicated that in spite of his caloric intake being 4200 calories a day and no reported meal refusals, his weight was still decreasing. The ISPA further documented that the IDT discussed possible causes, such as his psychotropic medications, his family not visiting, and the use of different scales. Although these issues were possible causes for his weight loss, there was no mention of the pituitary adenoma as a possible contributing factor to his weight issues. In addition, the discussion of his elevated prolactin levels, which could be related to his psychotropic medication, did not include the possibility that the pituitary adenoma also could be contributing to his elevated levels. Of major concern, the discussion of his high prolactin levels did not generate an IHCP intervention, as the psychiatrist recommended, during the ISPA meeting on 6/5/17, for bimonthly breast exams for lactation and tenderness, as well as noting any increase in size. Although the IDT was discussing many of these health issues and was collecting some data (i.e., behavioral data, weights, thyroid levels, and prolactin levels), it did not

appear the IDT was aggregating these data and comparing them with the medication and medication changes prescribed for the treatment of his pituitary adenoma. This was a significant deficit in the assessment and oversight of this individual's health status. Clearly, the IDT needs considerable education regarding this diagnosis in order to comprehensively monitor his risks, clinical data, and overall progress of his health status.

- Although the documentation in the ISPAs provided indicated that Individual #124's IDT had been discussing his falls and the episodes when he lowered himself to the floor, according to the Center's data provided in response to request TX-RG-1711-IV.1-20, he continued to have falls. The data indicated that he had fallen on the following dates: 1/12/17, 2/5/17, 2/11/17, 2/13/17, 4/4/17, 5/27/17, 7/26/17, 7/27/17, 9/27/17, and 10/23/17, which resulted in a fracture to his left middle finger. Based on review of the ISPAs, the IDT had not conducted a clear analysis of his falls by comparing clinical data, such as medication changes or postural blood pressures, to his aggregated fall data to attempt to identify the cause(s) of his falls. Given that he had experienced a fall in April 2016 at a group home prior to his admission to RG State Center that resulted in a subdural hematoma, the IDT's lack of action was very concerning. In addition, no data were found addressing how often he used the gait belt versus a wheelchair (i.e., there may have been less falls because he was using a wheelchair). There was also no indication that the IDT assessed the cause of him lowering himself to the ground. Despite the interventions that the IDT initiated, such as having his pants shortened, one-to-one staffing, obtaining orthopedic shoes, and treatment from Physical Therapy, his episodes of falls continued with a resulting fracture of his left middle finger in October 2017. In addition, his IHCP only included two interventions, including staff to report all falls to nursing for assessment, and staff to follow PNMP supports for all transfers and mobility. Clearly, this plan was not sufficient to meet his needs, and it had not prevented him from falling.
- On 9/12/17, Individual #143 was hospitalized with a gait change, change in behavior, elevated sodium, hypothermia, and hypotension, and was diagnosed with sepsis and a UTI. Although the ISPA, dated 9/25/17, indicated that the IDT changed the rating for the risk area from low to high, and planned to update the IRRF and IHCP, no updates were found.
- The ISPAs clearly demonstrated that starting in June 2017, Individual #36's IDT met timely when she began having falls. However, the IDT had not addressed some issues. For example, the IDT reviewed some data along with data related to Individual #36's falls and unsteady gait, such as the times of day and the taper of Lamictal. However, according to the ISPA documentation, additional factors were not included when analyzing her change in status, such as vital signs that were taken at the time of these incidents, postural blood pressures (i.e., these were not taken even though she was on psychotropic medications that can cause orthostatic hypotension), any changes in medication blood levels, knee pain with edema, weight gain, sleep status (i.e., often, she would not sleep in her room), possible seizure activity, etc. In addition, aside from the dates of her medication taper, the IDT did not implement a consistent system to gather data regarding her status. Although regular IPNs addressed her status, nurses did not consistently use assessment criteria that would be needed to note patterns. Without a structured system in place to aggregate several individual factors, identifying the etiology of her change in status becomes difficult, if not impossible.
- Individual #129 experienced significant weight gain. In July 2016, she weighed 125.6 pounds, and in November 2017, she weighed 164 pounds. A review of the ISPAs indicated that on 10/10/17, the "IDT does not have any recommendations. She was evaluated by dietician and changes were made to her caloric intake." It did not appear that the IDT conducted a comprehensive review of her weight to determine the cause(s). In addition, as her weight continued to increase since her ISP meeting on 7/6/17, the IDT made no changes to her IHCP.

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: 1) nurses administering medications according to the nine rights; 2) nurses adhering to infection control procedures while administering medications; and 3) nurses following individuals' PNMPs during medication administration. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators 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	114	51	124	144	3	74	143	36	129
a.	Individual receives prescribed medications in accordance with applicable standards of care.	71% 12/17	1/2	2/2	1/2	2/2	1/2	1/2	0/1	2/2	2/2
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/5	0/1	N/A	0/1	N/A	0/1	0/1	0/1	N/A	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).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	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	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A

	IHCP or acute care plan should define.										
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.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
f.	Individual's PNMP plan is followed during medication administration.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	100% 7/7	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1	N/A
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.	86% 6/7	N/A	0/1	1/1	1/1	1/1	N/A	1/1	1/1	1/1
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.	33% 1/3	N/A	0/1	1/1	N/A	N/A	N/A	0/1	N/A	N/A

Comments: The Monitoring Team conducted record reviews for all nine individuals and observations of eight individuals. Individual #143 was in the hospital during the onsite review week, so an observation was not completed.

a. and b. Problems noted included:

- For Individual #114, the 9/19/17 medications for 8:00 p.m. were circled on the Medication Administration Record (MAR) without explanation.
- For Individual #124, morning medications on 7/5/17 were circled on the MAR without explanation.
- For Individual #3, medications were circled on the MAR from 7/13/17 through 7/27/17 without explanation.
- For Individual #74, on 7/20/17, medications were either circled, or a designation of "r" was noted on the MAR without explanation.
- For Individual #143, the medications for 7/13/17 were circled without explanation.

c. It was positive that during the observations medication administration for eight individuals, nurses followed the nine rights.

d. For Individual #143, his IHCP included an action step and information about where nursing staff would document lung sounds obtained during medication administration, and nursing staff were documenting these assessments. This was great to see.

e. On 9/1/17 or 9/3/17, for Individual #114, the nurse did not document the site or the reason for the administration of intramuscular (IM) Rocephin.

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

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

h. For the records reviewed, evidence was present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed, which was good to see.

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. On a positive note, it was clear that nurses audited records frequently, identified MAR blanks, and completed variance forms for these occurrences.

For Individual #51, for 6/24/17, Medication Variances forms did not clearly indicate the nature of the variances. More specifically, it was unclear whether 8:00 p.m. medications were given too early (at 6:30 p.m. per the variance form), or if there were additional issues since the form noted 119 medication variances were generated from an investigation. In addition, no indication was found that the PCP was notified of these variances, because this area on the form was blank.

For Individual #143, a variance form indicated that on 8/23/17, Clonazepam 0.5 mg and Calcium were found in a medication cup in the Medication Room and the MAR did not indicate that medications were not given. The variance form did not indicate if the nurse notified the PCP, because the date/time of notification and PCP comment sections were left blank.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Overall, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. In addition, continued work was needed to ensure that IDTs referred individuals that met criteria for PNMT involvement, or the PNMT made self-referrals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129

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	0/2	0/1	0/1	0/2	0/2	1/2	0/1	N/A	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	0% 0/12	0/2	0/1	0/1	0/2	0/2	0/2	0/1		0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/12	0/2	0/1	0/1	0/2	0/2	0/2	0/1		0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/12	0/2	0/1	0/1	0/2	0/2	0/2	0/1		0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/12	0/2	0/1	0/1	0/2	0/2	0/2	0/1		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;	50% 3/6	N/A	1/1	0/1	N/A	N/A	N/A	1/1	1/2	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6		0/1	0/1				0/1	0/2	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	17% 1/6		0/1	1/1				0/1	0/2	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6		0/1	0/1				0/1	0/2	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/6		0/1	0/1				0/1	0/2	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/6		0/1	0/1				0/1	0/2	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: choking, and falls for Individual #114; choking for Individual #51; GI problems for Individual #124; falls, and weight for Individual #144; aspiration, and falls for Individual #3; choking, and falls for Individual #74; falls for Individual #143; and falls for Individual #129.

a.i. and a.ii. Individual #74's IHCP for choking included a goal/objective related to taking thin liquids throughout his meal. It was

clinically relevant, but not measurable (i.e., "consistently" was not measurable, and it was unclear whether it was his intake of the liquids, or staff's compliance with offering the liquids that was to be measured). The goal also included only two trials, and the rationale for this was unclear.

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 for Individual #51; weight for Individual #124; aspiration for Individual #143; falls, and weight for Individual #36; and weight for Individual #129.

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

- Upon his admission to Rio Grande SC on 12/7/16, Individual #124 weighed 135 pounds. On 1/6/17, he met criteria for referral to PNMT, when he had lost seven pounds in one month (i.e., more than 5% weight loss). On 4/15/17, his weight of 122.8 pounds showed continued weight loss. It was not until 5/2/17, that his IDT referred him to the PNMT.
- For Individual #36, different documents that the Center submitted listed different numbers of falls, and different dates for falls. However, it appeared that she fell as many as seven times in June, between one and five times in July, six times in August, seven times in September, and seven times in October. On 6/25/17, the PCP ordered that she use a wheelchair as needed. However, it was not until 10/5/17 that the PNMT conducted a review.
- Individual #129met criteria for referral to the PNMT in August with weight loss from 157 pounds in July to 148 in August, but her IDT did not refer her. She met criteria again for weight gain in September when her weight increased from 148 to 162 pounds, but her IDT did not refer her.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: weight for Individual #124.

a.iii. through a.v, and b.iv. through b.vi. Overall, in addition to a lack of measurable goals/objectives, integrated progress reports with data and analysis of the data often were not available to IDTs. 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. 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 Score	114	51	124	144	3	74	143	36	129
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	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	for completing the action steps.										
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	11% 1/9	N/A	0/1	0/1	0/2	0/1	N/A	0/1	1/2	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	N/A	0/1	0/1	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 often was not found to confirm the implementation of the PNM action steps that were included in IHCPs.

b. As discussed with regard to Outcomes 1 and 2 for Physical and Nutritional Supports, IDTs often did not make referrals to the PNMT when needed, and did not take action on their own to address significant changes of status. As another example, Individual #144 had as many as 19 falls within the last year. Since 4/4/17, his IDT held only one ISPA meeting to address the 12 falls that had occurred since then. The IDT had not identified and/or addressed the etiology of the falls.

c. For Individual #51, it was unclear whether or not the PNMT discharged him, or why they no longer monitored his weight.

According to PNMT minutes and an ISPA, on 8/22/17, the PNMT discharged Individual #124. However, as of 8/1/17, the PNMT documented that they would no longer monitor the other goals they outlined in their assessment beyond his weight. They stated they were referring the other three goals back to the IDT. There was no evidence that they had collaborated to develop an appropriate IHCP to address these issues. The ISPA stated that he had met his weight goal, but no summary was provided to identify how he would maintain that or prevent weight loss again. The ISPA only stated that the IDT would check his weight monthly. It stated that he had no signs or symptoms of aspiration, and, as such, had met his goal, but provided no discussion of how to address this moving forward. The PNMT had been monitoring his bowel movement log and his bowel movements were normal given his lack of colon at 6 to 7, though it was not clear if they meant daily weekly, monthly, etc., and again the recommendation was to check his bowel movement daily.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.

Summary: During numerous observations, staff 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 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.	49% 23/47

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.	20% 1/5
Comments: a. The Monitoring Team conducted 47 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during zero out of two observations (0%). Staff followed individuals' dining plans during 22 out of 43 mealtime observations (51%). Staff completed transfers correctly during one out of two (50%) observations.		

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: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
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.	0% 0/1							0/1		
Comments: a. As discussed above, Individual #143's PNMP indicated that oral feeding would precede PEG-tube feeding, but provided no other guidelines. In addition, his IHCPs did not outline the parameters for the use of the tube.											

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: IDTs overall did not have a valid way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	18% 4/22	0/1	1/7	0/1	0/4	0/3	N/A	3/4	0/2	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/22	0/1	0/7	0/1	0/4	0/3		0/4	0/2	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/18	0/1	0/7	0/1	0/4	0/3		N/A	0/2	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/18	0/1	0/7	0/1	0/4	0/3		N/A	0/2	

e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/18	0/1	0/7	0/1	0/4	0/3		N/A	0/2	

Comments: a. and b. The following provide examples of findings related to the OT/PT goals/objectives that the Monitoring Team reviewed:

- Although the PT identified goals/objectives for Individual #114, the IDT did not include them in the ISP or an ISPA. Similarly, the OT and PT identified goals/objectives for Individual #3, but the IDT did not include them in ISPAs.
- The goals/objectives that were clinically relevant and achievable, but not measurable were Individual #51's objective to lock and unlock his wheelchair brakes, and Individual #143's direct therapy PT goals. Although the OT also proposed direct therapy for Individual #143, the OT did not outline goals. Individual #143's PT goals were developed in October 2017, so at the time of the document request, monthly reviews were not yet due.
- An IPN was found for Individual #51 that indicated he was to receive direct therapy twice a week for eight weeks, beginning on 3/9/17. The IPN outlined three goals, but these goals were different from a consultation completed on 3/12/17, which outlined three different goals. The clinical relevance of these goals was unclear, given the differences and the lack of assessment information to establish the need for therapy, the rationale, and the individual's baseline.
- Individual #74 and Individual #129 had functional motor skills, so goals/objectives were not relevant to them. Individual #74 was part of the outcome group, so a limited review was conducted for him. Individual #129 was part of the core group, so a full review was conducted for her.

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress integrated reports with data and analysis of the data often were not available to IDTs. 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.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/10	0/1	0/2	0/1	0/1	0/2	N/R	0/2	0/1	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% 0/7	0/1	0/1	N/A	0/1	0/1		0/2	0/1	N/A

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. At times, multiple monthly reviews were "pending" (e.g., Individual #3, Individual #51, Individual #143).

b. The following provide examples of problems noted:

- On 10/23/17, the PT discharged Individual #114 from direct services, but the summary did not provide sufficient data related to goals and establishment of baselines. In addition, the IDT did not conduct an ISPA meeting to discuss the recommendation to discharge her, and/or to discuss recommendations for further strategies to address her ambulation issues and fall risk. Individual #114 had experienced at least five falls since re-admission, three of which occurred during the time period that she was receiving direct PT services. The PT's documentation, including the discharge summary, made no reference to these falls, and on 10/26/17, she fell an additional time, after discharge from PT.
- An IPN was found for Individual #51 that indicated he was to receive direct therapy twice a week for eight weeks, beginning on 3/9/17. Data was not found to substantiate that this service was provided, nor was an ISPA found to show the IDT agreed to discharge him from services.
- For Individual #144, the documentation was confusing. From April through June 2017, QIDP monthly reviews included recommendations to discharge him from direct PT services. However, PT progress notes were repeated in the summaries through the July monthly report for June. On 4/24/17, an ISPA noted that PT services would be discontinued consistent with a PT IPN on the same date. However, on 5/31/17, an ISPA stated the PT was still providing him with services, and the PT continued to write progress notes. Again, on 7/13/17, the PT recommended he be discharged from services, but an ISPA was not found to show that the IDT approved this discharge.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.

Summary: It was concerning that some individuals observed did not have prescribed adaptive equipment, some individuals were using equipment that was not included in their PNMPs, and some individuals had adaptive equipment that did not appear to fit them well. Center staff are encouraged to address these issues quickly. These indicators will remain in active oversight.

[**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]

#	Indicator	Overall Score	Individuals: 22	51	46	71	63	8	4	29	3
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	64% 9/14	0/1	1/1	0/2	1/1	0/1	1/1	1/1	1/2	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	50% 7/14	0/1	1/1	0/2	1/1	0/1	0/1	1/1	0/2	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	21% 3/14	0/1	0/1	0/2	0/1	0/1	0/1	1/1	0/2	0/1
		Individuals:									
#	Indicator		114	19	85						

a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.		1/1	1/1	1/1						
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.		1/1	1/1	1/1						
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1	1/1						

Comments: a. The Monitoring Team conducted observations of 14 pieces of adaptive equipment. Individual #63 had a gait belt that was not identified in the PNMP. Similarly, Individual #29's bilateral gloves were not in his PNMP. Individual #22's orthopedic shoes, and Individual #46's eyeglasses and dentures were not available.

b. Individual #8 was sitting in her dining chair, and leaning to the left throughout the meal.

c. Based on observation of Individual #51, Individual #71, Individual #3, and Individual #19 in their wheelchairs, the outcome was that they were not positioned correctly. As noted above, Individual #8 was leaning to the left throughout her meal when seated in her dining chair. Individual #29's lift vest did not appear to fit correctly, and it is unclear why this option is used as opposed to a gait belt that would be less stigmatizing. 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. At the last review, no indicators had sustained high performance scores to be moved the category of requiring less oversight. For this review, two other indicators will be moved to this category, in engagement.

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.

For ISPs, without personal goals that are individualized, measurable, implemented, and for which data are collected, it is impossible to determine progress.

The content of about half of the written skill acquisition plans was complete. A common missing component was clear training instructions. One-third of the SAPs observed by the Monitoring Team were implemented as written. No SAPs were scored as progressing. The majority had insufficient data. Others showed no progress.

A little less than half of the individuals directly observed by the Monitoring Team were regularly and frequently engaged in activities. Generally, though, engagement appeared to be improved relative to the last review. Specifically, there were fewer individual's wandering the residential units during the day. The vocational area, especially the courtyard, was much improved in terms of the variety of activities and individuals participating, being alert, etc.

One of the individuals attended the local high school. His educational services were integrated into his current ISP.

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

It was concerning that some individuals' AAC devices were not present or readily accessible, and that when opportunities for using the devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in these areas.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Without personal goals that are individualized, measurable, implemented, and for which data are collected, it is impossible to determine progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	51	103	114	97	36	129			
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. There was no basis for assessing progress as the IDTs frequently failed to develop personal goals that were also measurable. The Monitoring Team found the continued 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	51	103	114	97	36	129			
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 many staff knew the preferences of individuals, however, overall staff knowledge regarding individuals' ISPs was insufficient to ensure its implementation, based on observations, interviews, and lack of consistent implementation.											

40. Action steps were not consistently implemented for any individuals, as documented elsewhere in this section and throughout this report.

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: Without reliable data, it is impossible to assess progress. The Rio Grande SC SAP team, however, appeared to understand that they needed to ensure that all SAPs had integrity/reliability assessments at an established frequency, ensure that SAPs were conducted as scheduled, and ensure that decisions to continue, discontinue, or modify SAPs were data-based. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 142	51	103	114	50	46	22	53	97
6	The individual is progressing on his/her SAPS	0% 0/19	0/2	0/3	0/1	0/1	0/3	0/3	N/A	0/3	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	33% 1/3	N/A	0/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	33% 1/3	N/A	0/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments:

6. No SAPs were scored as progressing. The majority of SAPs (e.g., Individual #103's state the reasons he is taking Colace SAP) had insufficient data, however, they were also scored as 0 because the data were not demonstrated to be reliable (see indicator 5). Additionally, some SAPs were not making progress (e.g., Individual #51's match shapes/color SAP). Finally, three SAPs (e.g., Individual #22's wash clothes SAP) were scored as N/A because there was insufficient data to evaluate progress even though the data were demonstrated to be reliable.

8-9. Individual #51's push his wheelchair SAP was not progressing, however, his QIDP monthly report indicated that staff would be retrained to address the lack of progress. Individual #114's operate a sewing machine, and Individual #51's match shapes/colors SAPs, were also judged as not progressing, however, no action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP).

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: The quality of the SAPs dramatically improved since the last review. The new statewide format template helped set the occasion for this, as well as the additional attention paid by Rio Grande SC SAP developers. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
13	The individual's SAPs are complete.	45% 10/22	0/2	0/3	0/3	1/1	1/3	1/3	1/1	3/3	3/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Rio Grande SC recently began implementing a new SAP training format. This monitoring review, however, included a combination of the old and new format SAPs.

Forty-five percent of the SAPs (all using the new format) were judged to be complete. This represented a substantial increase from the last review when no SAPs were rated as complete.

A common missing component of both the new and old format SAPs was the absence of clear SAP training instructions. All the old format SAPs indicated that they utilized forward chaining. Neither the SAP training sheet nor the SAP data sheet, however, indicated the current training step or how to present steps prior to or following the training step (e.g., Individual #51's push the wheelchair SAP).

Several of the new format SAPs did not clarify which steps were to be conducted by the individual and which by the training staff (e.g., Individual #142's make a smoothie SAP).

Finally, several (of both formats) did not clearly use an individualized reinforcer for correct behavior (Individual #103's identify numbers SAP). The use of potent reinforcers following the correct implementation of a skill is critical to successful SAPs.

Outcome 5- SAPs are implemented with integrity.												
Summary: Now that Rio Grande SC was attending to SAPs, including improvement in SAP quality, efforts were recently initiated to ensure correct implementation. These efforts were showing some effects, but as evident by the scoring for these two indicators, most SAPs were not yet being implemented as written and the Center was not yet fully and regularly observing for (and training for) correct implementation. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
14	SAPs are implemented as written.	33% 1/3	0/1	N/A	0/1	N/A	N/A	N/A	N/A	1/1	N/A

15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/22	0/2	0/3	0/3	0/1	0/3	0/3	0/1	0/3	0/3

Comments:
14. The Monitoring Team observed the implementation of three SAPs. Individual #53's state the rules of using social media SAP was implemented as written. Individual #142's make a smoothie SAP and Individual #103's brush teeth SAP were not implemented using the exact steps in the training plan. Although the training steps utilized by the PNAs in implementing these SAPs appeared to represent reasonable procedures for training these skills, for optimal learning it is important that all staff use exactly the same procedures for training.

15. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. At the time of the onsite review, Rio Grande SC had recently begun to assess SAP integrity. They had not yet established a specific schedule of SAP integrity (e.g., each SAP assessed at least once every six months), but planned to do so.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.

Summary: Performance decreased for both indicators, both of which will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
16	There is evidence that SAPs are reviewed monthly.	23% 5/22	0/2	2/3	3/3	0/1	0/3	0/3	0/1	0/3	0/3
17	SAP outcomes are graphed.	45% 10/22	0/2	2/3	3/3	0/1	0/3	1/3	1/1	0/3	3/3

Comments:
16-17. The majority of SAPs were reviewed in QIDP monthly reports, however, for all individuals other than Individual #51 and Individual #103, these reviews were several months old, indicating that monthly reviews were not regularly occurring.

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

Summary: Rio Grande SC attended to individual engagement and activities more so than was seen at the last review. The Center continued to regularly measure engagement and to have goals for each setting on campus. This was the case for all individuals for this review and for the two previous reviews, too. Therefore, indicators 19 and 20 will be moved to the category of requiring less oversight. The number of individuals who were observed to be engaged and the number who met the Center's own goals improved compared with the last two reviews. These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	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.	44% 4/9	0/1	0/1	1/1	1/1	0/1	1/1	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 Individual #103, Individual #22, Individual #53, and Individual #51 consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

Generally, the Monitoring Team found that engagement appeared to be improved relative to the last review. Specifically, there were fewer individual's wandering the residential units during the day. The vocational area, especially the courtyard, was much improved in terms of the variety of activities and individuals participating, being alert, etc.

19-21. Rio Grande SC regularly conducted engagement measures in the residential and day treatment sites. The facility established an engagement goal of 65% in all treatment sites. Four individuals, Individual #97, Individual #46, Individual #114, and Individual #103, 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: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	51	103	114	50	46	22	53	97
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-24. There was evidence that all of individuals participated in community outings. This was good to see, 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. None of the individuals had 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: Criteria were met for this indicator, which was good to see. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	22								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								
Comments: 25. Individual #22 attended the local high school. 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	114	51	124	144	3	74	143	36	129
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/2	N/A	0/1	N/A	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% 0/2		0/1		0/1					
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/2		0/1		0/1					
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/2		0/1		0/1					
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/2		0/1		0/1					
Comments: For the two individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals.											

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: Without clinically relevant, achievable, measurable goals that were included in individuals' ISPs, and on which data and analysis of data were included in QIDP reviews, IDTs did not have a valid method for measuring individual outcomes related to communication. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	N/A	0/1	0/1	0/1	0/1	2/3	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	22% 2/9		0/1	0/1	0/1	0/1	2/3	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/9		0/1	0/1	0/1	0/1	0/3	0/1	0/1	
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/9		0/1	0/1	0/1	0/1	0/3	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% 0/9		0/1	0/1	0/1	0/1	0/3	0/1	0/1	

Comments: a. and b. Individual #114 and Individual #129had functional communication skills. For some individuals, the lack of a quality assessment, including thorough assessment of the individuals' potential for using AAC devices or systems resulted in negative scores (e.g., Individual #51, Individual #124, Individual #143, and Individual #36). Without such an assessment, the need for a goal/objective could not be ruled out.

For Individual #144, the Speech Language Pathologist recommended the following goal: "With visual and verbal cues, [Individual #144] will request to listen to 1 of 3 preferred CDs using the 'I want' button on the Go Talk 9+ with 33% accuracy for the month over three consecutive months." Although it appeared that the IDT approved this goal related to the use of an AAC device, the IDT did not include it in the ISP, and no evidence was found of implementation.

The goals/objectives that were clinically relevant, as well as measurable were Individual #74's SAP and direct therapy goals related to requesting preferred activities using an AAC device. The SLP recommended another goal to point to a snack picture in his wallet, and although it appeared the IDT approved it, it was not in the ISP action plans, and evidence of implementation was not found.

c. through e. With regard to Individual #74's clinically relevant and measurable goals/objectives, the QIDP monthly reviews were

"pending" for August, September, and October, so the IDT did not have timely summaries of data and analysis of this data for these programs.

As noted above, Individual #114 and Individual #129 had functional communication skills. Both were part of the core group, so full reviews were conducted for them. For the remaining seven individuals, the Monitoring Team completed full reviews.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	114	51	124	144	3	74	143	36	129
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/3	N/A	N/A	N/A	0/1	N/A	0/2	N/A	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included:

- For Individual #144, no evidence was found of implementation of his AAC SAP.
- Although some integrated reviews included data for Individual #74's goals/objectives, the Center's submission indicated that the reviews for August, September, and October were "pending."

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 should focus on ensuring individuals have their AAC devices with them, and that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	29	97	19						
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	33% 1/3	1/1	0/1	0/1						
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	33% 1/3	1/1	0/1	0/1						
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	0% 0/1									

Comments: a. and b. Individual #97's switch to request food was not working consistently. In addition, staff did not follow the plan as written. Individual #19 did not have her device with her at the day program, despite the items on the device being available there.

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. 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.

There were four transitions in the last six months. One of these four individuals returned from her placement due to behavioral problems. Another individual (not one of these four) also was re-admitted from his group home to where he moved more than six months, but less than a year, ago. This percentage of returns means that the Center and the transition department need to take a close look at the reason that individuals have serious difficulty in the community, and what they can do to reduce the likelihood in the future. One likely variable is change to psychiatric medication regimens that occur shortly after transition.

There were currently no individuals on the active referral list at Rio Grande SC. The transition department was comprised of two staff: the APC and the dual-roled transition specialist/post move monitor. The latter was a vacant position. The APC, however, has been in her position for a number of years and was very experienced with the community transition process. Even though there were challenges in transitions and transition successes, there also was improvement in the department's transition planning, CLDPs, and post move monitoring protocols.

The Center had some made progress toward defining more specific criteria related to pre-move training. The respective IDTs developed 65 post-move supports for Individual #48 and 62 post-move supports for Individual #114. There were significant improvement in the identification and detailed nature of transition supports, which was positive. Many supports provided explanatory notes that clarified the purpose, intent, and staff instructions. Even so, some supports did not provide the post move monitor (PMM) with measurable criteria or indicators that could be used to ensure supports were being provided as needed (e.g., some use of vague language).

The Center had identified many supports for each individual; transition staff and IDTs had made diligent efforts to address their needs. Still, neither of these CLDPs fully and comprehensively addressed all support needs and preferences.

It was positive that transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. IDT members actively participated in the transition planning process. Individuals at Rio Grande SC who were referred for transition received a lot of attention from the transition department and transitions occurred in a timely manner.

Post-move monitoring was completed as required. Reliable and valid data availability was improved from the previous site visit. The Center had made improvement toward identifying the required evidence to be used to confirm whether supports were in place as needed. These two CLDPs consistently requested that at least two, and frequently three, of the prongs of evidence (documentation, interview, and observation) be used to obtain valid and reliable data. The PMM, however, rarely documented collecting all the types of required evidence. Individuals were receiving most, but not all, of the supports designated in the CLDPs.

One individual had many negative events occur in the months following her transition and was eventually re-admitted to Rio Grande SC. Although improvements in CLDP development and post move monitoring had occurred over the review period, additional work was needed; some of that additional work might have led to a more successful outcome for this transition. It was positive that the Center identified the provider issues that impacted the transition, but it also needed to use the PDCT process to critically analyze the Center's actions. The Monitoring Team identified several such issues the Center should have considered, but did not.

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: Rio Grande SC continued to make progress in creating a comprehensive list of supports and in writing these supports in a way that was measurable so that the provider, IDT, and post move monitor could determine their presence. The Rio Grande SC transition department staff continued to be extremely responsive to feedback from the Monitoring as evidenced by the many positive comments below regarding the indicators and sub-indicators of this outcome. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	48	114								
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: Four individuals transitioned from the Center to the community since the last review. Two were included in this review (Individual #48, Individual #114). Both individuals transitioned to group homes that were part of the State's Home and Community-based Services (HCS) program. One (Individual #114) returned to the Center shortly after her 90-day PMM visit due to behavioral and psychiatric issues. The Monitoring Team reviewed these two transitions and discussed them in detail with the Rio Grande SLC 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 individuals' needs and preferences will 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 any needed modifications. Overall, the Center had made progress, but did not yet meet criterion for this indicator. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) can accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

a. Pre-move supports: The respective IDTs developed 11 pre-move supports for Individual #48 and 12 pre-move supports for Individual #114.

- Pre-move supports still needed to address provider staff training in a measurable manner. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained and the training methodologies to be used and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety.
    - The Monitoring Team found that the Center had some made progress toward defining more specific criteria related to pre-move training. In the CLDP narrative, the Center had included a section for each discipline assessment that addressed the identification of staff to be trained, the overall expectation for the outcome of the training, the training methodologies to be used, and how staff competencies would be measured and/or demonstrated. This was a commendable approach that could be used effectively by the IDTs toward meeting compliance.
    - This protocol, however, had not yet resulted in improved pre-move training supports for these two individuals because the IDT did not effectively use these pre-move training recommendations to develop formal training supports. Both CLDPs included only two identical pre-move training supports related to medical and health care needs and to the psychiatric support plan, but did not include the others as defined in the CLDP narrative, such as for physical/nutritional needs and behavioral supports.
    - In addition, neither of the individuals actually had a psychiatric support plan, even though the IDTs prescribed related pre-move training supports. The Center should be cautious when using a CLDP template to be sure the resulting document reflects supports that are both individualized and pertinent.
- The pre-move training supports that were included did not provide specific competency criteria needed to confirm staff knowledge. The Monitoring Team reviewed the Center's pre-move provider testing to assess whether it clearly and comprehensively addressed criteria that would evidence staff knowledge and competence. It did not. For example, both CLDPs included a pre-move training support for the individuals' medical diagnoses, medications and side effects to report, administration of medications, and monitoring of bowel movements. The testing did not include questions regarding these needs or require any related demonstrations of competence.

b. Post-Move: The respective IDTs developed 65 post-move supports for Individual #48 and 62 post-move supports for Individual #114. The Monitoring Team noted significant improvement in the identification and detailed nature of transition supports, which was positive. Many supports provided explanatory notes that clarified the purpose, intent and staff instructions. This improvement was positive. Even so, some supports did not provide the PMM with measurable criteria or indicators that could be used to ensure supports were being provided as needed. For example:

- For both individuals, the IDTs sometimes used vague language that did not provide clear expectations about needed staff actions or about outcomes. For example:
  - For Individual #48, the IDT developed a support that indicated his feet and legs would need to be checked "frequently" for skin breakdown.
  - For Individual #114, a support called for the provider to refer to her medical provider for any "significant changes" in weight and or nutritional needs.
  - For Individual #114, a support indicated she "can actively participate" at a local church as a charity volunteer.
- A series of behavioral supports for Individual #48 did not consistently specify when staff actions should take place. For example, one support stated that staff should take actions, such as to prompt him to remove himself away from a peer, rather than prompting peer to move away, while another stated simply "move peers away." Neither provided any context about when these staff actions should occur. The staff instructions were not preceded by any details about behaviors Individual #48 might exhibit that would require these actions. As they stood, the supports appeared to be contradictory. This appeared to be a result of the IDT's effort to create supports that were distinct and measurable (which was good to see), but the IDT did not provide the correct context for taking the prescribed actions. The Center should consider how it could develop more coherent behavioral supports
- The IDT for Individual #48 did not always provide realistic due dates. A support for opportunities to attend preferred outings/restaurants indicated it was due on the day of transition and daily thereafter. As written, this support appeared to require that Individual #48 have daily opportunities to attend outings or go to restaurants. While this was likely not the intent of the IDT, this wording left it up to the PMM to decide whether the frequency with which he had such opportunities indicated compliance.

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. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed all support needs and did not meet criterion, as described below.

a. Past history, and recent and current behavioral and psychiatric problems: To meet criteria, the IDTs should continue to make improvement toward developing current and comprehensive supports, as described below:
   - Neither CLDP included a pre-move support for staff training of the individuals' positive behavior support plan (PBSP) or any behavioral strategies.
   - Both individuals had post-move supports that provided descriptions of behavioral strategies, which was positive, but these did not specify competency criteria or require competency demonstration.
   - The CLDP did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. For example, for Individual #48, the annual medical assessment documented he had history of sexually inappropriate behavior in public, such as masturbation**.** For Individual #114, an ISPA indicated she had required chemical restraint at least twice in the months shortly before her transition for aggressive, self-injurious, and destructive behavior. The CLDP did not include supports for staff knowledge of this relevant behavioral history.
   - Per her pre-move ISP and ISPA, Individual #114 required Level II training for her PBSP, which required demonstration/role play of all steps of prevention strategies and response strategies. These documents indicated

competence needed to be determined by appropriate descriptions and demonstration of strategies for preventing challenging behavior, teaching replacement behavior, and responding to challenging behaviors. The IDT did not develop supports that conveyed the recommended intensity of staff preparation to meet her behavioral needs, but should have. Pre-move documentation indicated the behaviors that required this training were continuing with some frequency and intensity in the months preceding her transition, as described further in the next paragraph.

- Approximately one month before transition, on 2/6/17, the Registered Nurse Case manager (RNCM) expressed reservations about Individual #114's pending transition, in part due to recent behavior and the need for a chemical restraint. The Center psychiatrist indicated he was increasing two psychiatric medications due to those behaviors and the IDT would need to review February 2017 behavioral data before making a final determination. He further indicated a transition delay would be appropriate if behaviors were increasing. The IDT did not document a review of the February 2017 data.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. To meet criteria, the IDTs still needed to develop comprehensive supports in this area. For example:
    - Both CLDPs included supports for supervision needs in the community, but neither reflected these needs in a comprehensive manner. For example:
        - For Individual #48, the CLDP narrative recommended a routine level of supervision, within eyesight at all times because he had the potential to wander away, to approach doors he could open, and he required redirection back to his group. In addition, documentation indicated this level of supervision was needed due to a requirement for modified liquid consistency of honey thick liquids to prevent aspiration, and his propensity to drink other liquids, such as from unattended water bottles or water from faucets if not supervised closely. The CLDP included only a pre-move support that indicated he required 24-hour awake staff to attend to his personal care and needs.
        - For Individual #114, the CLDP included a post-move support for required level of supervision that was described as within eyesight in order for staff to monitor for risk of falls resulting from her periodic refusal to use her walker, as well as to monitor her fluid restrictions and possible ingestion of inedibles due to her diagnosis of pica. This was positive, but the CLDP did not include pre-move staff training and competency verification pertaining to these requirements. The Center should have confirmed provider staff had knowledge of her supervision needs no later than the day of her move. The support was also not comprehensive. Per the CLDP ISPA, supervision requirements also included staff to be within 10 feet when outside her living environment, as it related to falls, but the support did not reflect this.
    - Both individuals had risks for constipation, but neither CLDP included a support for bowel monitoring.
    - Per the IRRF, Individual #48 had history of recurrent wound complications with difficulty healing and required nightly Vaseline for the treatment/prevention of heel fissures. The CLDP did not include pre-move training supports related to wound complications or the need for Vaseline application to heels; rather, it included a non-specific support for training on administration of medications. A related post-move support indicated he had a medium risk for skin integrity, and called for Individual #48 to have zero infections related to impaired skin integrity, as evidenced by no need for antibiotic therapy through July 2017. The support recommended a personal grooming routine be followed on

a daily basis to decrease skin integrity issues, but did not address staff knowledge of the heel fissure concerns.
- For Individual #114, the speech-language pathologist (SLP) advised that provider staff should not tell Individual #114 no when she attempted to ingest an inedible, but rather offer her an alternative item and use response blocking. The CLDP did not include a specific support related to the ingestion of inedibles and how to respond.

c. What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Areas for improvement included:
   - For Individual #114, the CLDP indicated she wanted to improve her sewing and knitting skills and this was consistent with her ISP and PSI. The IDT did not identify any related supports that focused on these in a meaningful manner.
   - For Individual #48, the CLDP did not identify any important outcomes. He did have some very specific preferences, such as watching the Weather Channel, the Green Bay Packers, and Scooby Doo, as well as playing the piano and using the Wii. CLDP supports did not include any of these specific preferences.

d. Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion, as described below:
   - For Individual #48, the CLDP did not include a support for employment, day habilitation, or other meaningful day activities in integrated community settings.
   - For Individual #114, the vocational assessment indicated she was a great candidate for employment due to her level of functioning and her willingness to learn. It further indicated that she had good basic skills and good work attendance and that she wanted to work with plants, animals, children, sewing, and arts and crafts. The IDT did not develop assertive supports to address these strengths and aspirations. Instead, the CLDP included a vague support that stated Individual #114 would like to work in the community "one day" and that efforts by the provider to assist her should be completed in one year and evident in the post move monitoring process. The IDT did not specify the nature of the efforts.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports regarding behavioral strategies that included some elements of positive reinforcement and other motivating components. Still, the IDT did not assertively address some important strategies in this area for Individual #114. For example, the CLDP ISPA stated the Psychiatric Assistant emphasized Individual #114 should have time to talk with assigned staff for 10 minutes each morning and afternoon. The CLDP supports did not specify this requirement; instead, a support indicated she should be offered time to converse with group home staff regularly. While it was positive the IDT recognized this need and made an effort to include it in the CLDP, the support as written did not make the expectation clear.

f. Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed some supports related to teaching, maintenance, participation, and acquisition of specific skills, which was positive, but these were limited. For example:
   - For Individual #48, the CLDP provided some good instruction for staff related to maintaining communication skills, but did not include a specific support for using a picture schedule. The CLDP did not include any other specific skill acquisition.
   - For Individual #114, the CLDP included a support for learning to sort her laundry, which related to her expressed

desire to learn to wash and dry her clothes. This was positive. The IDT should have considered additional skill acquisition needs, based on assessments and her preferences. For example, the vocational assessment indicated she had expressed a desire to learn more about managing her own money and delighted in money management class, but the CLDP did not include supports for skill acquisition in this area.

g. All recommendations from assessments are included, or if not, there is a rationale provided: Overall, Rio Grande SC had a good process in place for documenting discussion of assessments and recommendations, including the IDT's rationale. To meet criteria, the IDTs should continue to work toward ensuring recommendations from assessments are consistently addressed and a coherent rationale provided when recommendations are deferred or declined. In addition to the vocational recommendation for Individual #114 described immediately above, other examples of recommendations not addressed as needed included:
   - Individual #48 had an ISP goal to participate in Special Olympics and a related goal to develop a relationship with a peer through practice and participation. The provider reported it was currently not involved in Special Olympics, but was in the process of rejoining. The IDT agreed to a recommendation for Individual #48 to continue to practice walking at the park and to participate in Special Olympics. The wording of the post-move support specified the requirement for walking in the park, but did not make clear an expectation he would participate in Special Olympics.
   - The IDT agreed to remove a recommendation for Individual #48 to continue to use a picture schedule. The offered rationale was that such a schedule was not available for him to take to the community. The IDT discussed that if Individual #48 has a difficult time in transition, a picture schedule could be implemented for him, but did not predict this as his pre-placement visit went very well and the provider did not anticipate any issues. This did not really address the full purpose for the picture schedule, which included promoting increased independence and self-direction.

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

Summary: Similar to improvements in the CLDP development, there were improvements in the post move monitoring process, too. With additional focus on the details of post move monitoring, which includes seeking out evidence for every support, ensuring all evidence identified in the CLDP is examined (or explained), and following-up on every problem, even more progress is likely to be seen. A new PMM will be appointed at some point in the near future. Thorough training and mentoring will be important. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 48	114							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
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 assessment 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 CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
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.	0% 0/1	0/1	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	0% 0/1	0/1	N/A							

Comments:

3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format, occurred at all locations where the individual lived or worked, and included comments regarding the provision of every support.

4. Reliable and valid data availability was improved from the previous site visit. The Center, however, needs to continue to work toward improving measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports. On a positive note, the Center had made significant improvement toward identifying the required evidence to be used to confirm whether supports were in place as needed. These two CLDPs consistently requested at least two, and frequently three, prongs of evidence (documentation, interview, and observation) be used to obtain valid and reliable data. The PMM rarely documented collecting all the types of required evidence, however. For example:

- In many instances, Individual #48's CLDP called for review of the support checklist or medical log as one form of evidence, but this was rarely documented by the PMM.
- For Individual #48, supports called for a body weight to be obtained within two days of transition. The PMM documented only speaking to the provider Registered Nurse (RN), who stated they were monitoring his weight. The weight was not specified. Another related post move support indicated a gain or loss of seven pounds in one month would be considered a significant change, but no baseline weight from which to make such an assessment was documented.
- Individual #114 had a support indicating provider staff should teach her to cook preferred meals and how to use all kitchen appliances. This had not occurred. Provider staff reported she preferred to sit at the table while staff prepared dinner instead of helping with the preparation. The PMM did not document interviewing Individual #114 as to whether this was correct.

5. Based on information the Post Move Monitor collected, neither of the individuals had consistently received supports as listed and/or

described in the CLDP, as detailed below:

- As described above, the Monitoring Team could often not evaluate or confirm whether individuals had consistently received supports due to the lack of reliable and valid data. The PMM's comments and evidence should address the full scope of each so that presence of supports could be assessed, but did not consistently do so. For example:
    - One of Individual #48's supports for behavioral health included objectives for aggression, property destruction and requesting a break. The CLDP indicated evidence should include interview with the case manager, interview with direct care staff, observation, and review of the behavioral log. The PMM checklist stated only that the PMM spoke to the day habilitation staff who reported no aggression. This did not address the full scope of the support and only included one of the four forms of required evidence. It did not confirm whether provider staff were knowledgeable of the specific strategies or whether Individual #48 had engaged in any property destruction or appropriately requested a break.
    - Also for Individual #48, a post-move support for dental indicated staff should use gestural and short, precise verbal prompting in a soft but firm voice for toothbrushing. The evidence required included an interview with the provider RN, an interview with direct care staff, and a review of the support checklist. The PMM only documented that group home staff had assisted him in brushing his teeth without any issues. This did not confirm staff knowledge of the instructions or reference any of the three forms of evidence reviewed to reach that conclusion.
- Individual #48's CLDP included a support for having the opportunity to purchase food items of his choice. The due date, per the CLDP, was October 13 and daily thereafter. The PMM documented the support had not yet started and would begin after his funds were transferred over. The support was marked as not applicable rather than as not in place.
- For Individual #114, examples of supports not in place as required included the following, with additional examples described in the next two indicators:
    - At time of the seven-day and 45-day PMM visits, the provider had not started applications for Individual #114's SSI benefits and representative payee status.
    - At time of the seven-day, 45-day, and 90-day PMM visits, the center psychiatrist had not completed recommended collaboration with his community counterpart regarding psychiatric medications and the recommendation not to make changes in those during the first six months.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but not always. In some instances, the Monitoring Team did not find enough documentation to make an evaluation and/or the support was not clear in its intent. Examples included:

- The PMM should not mark supports with pending due dates as either in place or not in place, unless the support was completed ahead of the pending due date. For supports that are not yet due and not yet completed, the PMM should so indicate and mark the support as not applicable at the time. If the provider can describe the plan for completion, the PMM should also document that. For Individual #48, the PMM marked some such supports as either in place and others as not in place, without a consistent approach or rationale.
- At time of the 45-day and 90-day PMM visits, the provider had not been able to begin the process of assisting Individual #114 to seek work opportunities due to behavioral issues, but the PMM Checklist indicated the support was as in place.
- At time of the seven-day PMM visit, the provider had not implemented a support for teaching Individual #114 to cook, in part due to concern for safety with appliances. Provider staff also reported Individual #114 stated she preferred to sit at the table

instead while staff prepared dinner. The provider had not implemented this support at the time of the 45-day and 90-day PMM visits, either. This was ostensibly for the same reasons, but the PMM did not so specify. In each case, the support was marked as in place, but should not have been. The PMM should have indicated the support had not been met and followed-up with IDT.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. To move toward compliance, the IDTs should focus on developing measurable supports that provide the PMM with clear criteria for evaluating whether corrective action is needed, and the PMM should, at a minimum, adhere to those requirements.

- For Individual #48, the PMM had not identified any instances of need for follow-up, but should have. For example, the PMM should have followed up on the lack of implementation of the support for purchasing preferred food at the time of the seven-day PMM visit. Per the CLDP, the Center was to provide $100 from Individual #48's trust fund on the day of move. The day of move documentation indicated that amount of money was provided for spending and outings, so it was unclear why the support could not have been implemented as required. Per interview with the transition staff, the PMM also questioned this at the time.
- At time of 45-day PMM visit, the PMM reported the community cardiologist had discontinued Individual #114's sodium labs on 4/20/17. The PMM should have obtained the cardiologist's rationale and provided that to the IDT for follow-up discussion. The Center provided no evidence this had occurred.
- The provider had not implemented Individual #114's support for participating as a volunteer at church, but the PMM Checklist did not document any follow-up.

9. The Monitoring Team observed post move monitoring of the 45-day review for Individual #48 at his day program and at his home. Overall, he was doing very well. The home and day program were part of an agency called Texas HCS. Post move monitoring was done by the APC, due to the vacancy in the PMM position. She conducted interviews with direct service staff and support staff (e.g., nurses). She also gathered relevant documentation. Her style was pleasant and interactive. Staff and the individual were responsive to her questions and interactions. Some aspects needed additional attention, such as ensuring that all of the evidence specified in the CLDP is examined, that presence of all medications are directly observed, and that leading questions are not used during staff interviews. Hiring processes were underway to recruit a new post move monitor.

10. The report of the 45-day review for Individual #48 that was observed by the Monitoring Team contained all of the supports and included brief commentary on each support. The comments sometimes stated that a support was being provided, but did not indicate how this was determined or at what level/amount/frequency the support was being provided (e.g., Individual #48 continues to attend the park nearby his house when he wants or as needed or scheduled). For the most part, staff interview was used to determine presence of supports. The CLDP called for documentation review, too, for most every support.

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 following transition. The other individual had many negative events and was eventually re-admitted to Rio Grande SC. Although improvements in CLDP development and post move monitoring had	Individuals:

occurred over the review period (as described in the other outcomes of this domain), additional work was needed and some of that additional work might have led to a more successful outcome for this transition. It is hoped that the comments below, for this outcome, will be helpful to the transition department as they deal with negative events in the future, and as they develop lists of CLDP supports to reduce the likelihood of negative events. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	48	114							
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	1/1	0/1							

Comments:

11. Individual #48 had not experienced a PDCT event.

Individual #114 had experienced multiple emergency room (ER) visits and psychiatric hospitalizations before being re-admitted to the Center on 7/13/17. Details included:

- The IDT held an ISPA on 5/4/17 covering PDCT events that occurred during a span between 4/28/17 through 5/4/17. The IDT received notification on 5/2/17 that Individual #114 had begun experiencing crisis events, including disrobing at the day habilitation program, hitting peers, and placing items in her underwear/vagina. The provider sent her to the ER on 4/29/17, where she became aggressive to the nurses, stated she wanted to kill herself and reported hearing voices. She remained there for two days pending hospitalization, but was released back to the provider when no beds became available. She returned to the ER on 5/3/17 for a similar event. On 5/4/17, she was taken by the police to a psychiatric hospital in the community for both self-injury and suicidal outcries and was admitted. Per the ISPA, Rio Grande SC staff noted these were common behaviors for her when she transitioned, even between dorms at the center. At the time of this 5/4/17 PDCT ISPA, the IDT indicated further nothing could have been done differently because provider staff had been trained twice.
- The IDT held another ISPA on 6/21/17 that documented a series of behavioral episodes including self-injury, aggression, property destruction, and inappropriate touching of others during the period from 4/29/17 through 6/13/17. She had several additional emergency room visits during this period.
- The IDT held an ISPA on 7/5/17 after Individual #114 pushed a peer, causing injury. She also broke windows at the group home and threatened to cut herself with the broken glass. The provider again sent her to the ER and she was subsequently admitted to the hospital. At that point, the provider indicated they could no longer serve her.
    - Per the documentation, the community Board Certified Behavior Analyst (BCBA) did not complete any provider staff trainings until 6/23/17 and did not complete her new PBSP until 6/25/17.
    - The ISPA described some issues that may have negatively impacted the management of these behavioral needs. These

included a finding that the community provider may not have approved the BCBA's hours in a timely manner, did not adhere to the behavioral strategies in the pre-move training, and made changes to Individual #114's psychiatric medications, despite a post-move support that recommended no such changes for the first six months after transition. Based on these findings, the IDT agreed it would not make future referrals to this provider.

- It was positive that the Center identified the provider issues that impacted the transition, but it also needed to use the PDCT process to also critically analyze the Center's actions during and after transition and use this information for process improvement in future transitions. The IDT did not document a full consideration and discussion of what the Center might have done differently. The Monitoring Team identified several such issues the Center should have considered, but did not. These included, as described throughout this section in the outcomes above and below:
  - A lack of formal pre-move training supports for the PBSP.
  - A lack of training for behavioral needs that was consistent with the Level II training and competency demonstration required at the Center.
  - A lack of a clear post-move support for behavioral consultation and when it needed to begin.
  - A lack of a clear support that identified her propensity to insert items into her vagina and the precautions the provider staff needed to follow. For example, per a pre-move ISPA, Individual #114 engaged in this behavior 19 times in November 2016, and the IDT was concerned enough at that time to discontinue a SAP that allowed her access to sewing materials. The IDT did not specify any pre-move training that required staff knowledge of this risk or related prevention techniques.
  - A lack of IDT follow-up on the support for collaboration between the Center and community psychiatrists.

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: There was improvement seen in all of these indicators, even though the various criteria were not fully met for many of them. In particular, each discipline transition assessment now included specific questions about provider staff training. This has the potential to be a very effective tool for ensuring that provider training and competencies are accurately defined in all areas. Attention to all aspects for all individuals for all transition activities, as described in detail in the comments below, is required. Scoring maintained or improved for all indicators. With sustained high performance, indicators 13 and 18 might be moved to the category of requiring less oversight after the next review. All of the indicators in this outcome will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	48	114							
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.	100% 2/2	1/1	1/1							
18	The APC and transition department staff collaborates with the LIDDA 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 improved, but did not yet meet criterion for this indicator. It was positive transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. This remained an area of need, however. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 days of transition:
  - It was positive that the Center documented its review of the Integrated Risk Rating Form (IRRF) for Individual #48 because this document typically contains a great amount of information provider staff need to know. The Center should ensure it updates the information contained in the IRRFs, but did not do so consistently. The Center did not provide an updated IRRF for Individual #114.
  - The Center did not provide updated psychiatric or pharmacy assessments/QDRRs for either individual.
  - For Individual #48, the IDT did not obtain a medical assessment within 45 days of transition. This assessment was dated 5/15/17 and did not contain current information, such as for completed testing for an H. Pylori stool antigen or the results of a completed abdominal ultrasound to rule out pathological findings related to a protuberant abdomen.

    - For Individual #114, the CLDP indicated the IDT reviewed a medical assessment dated 4/25/16, instead of the assessment provided in the document request, dated 2/13/17.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Assessments had improved in this content area since the previous review. IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that had been updated did not yet thoroughly provide recommendations to support transition. For example, the residential assessment for Individual #114 offered broad recommendations, limited to the following: opportunity to participate in outings, have her own personal items, and have a routine she follows every day.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. One particular example was the OT/PT assessment for Individual #114, which had an updated recommendations section that was limited to a statement that provider staff should "(p)lease read her PNMP and follow it. Call if you have questions."

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: (1) There was documentation to show IDT members actively participated in the transition planning process, (2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (3) 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. Both CLDPs met criterion for this indicator. Section IV of the CLDP document, entitled Community Living, provided a summary of transition activities that described the involvement of the individual and LAR/ family, the LIDDA, and Center staff. These were helpful in understanding how the Center's transition processes ensured necessary participation.

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: Training provided to community provider staff did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the materials, rosters, and competency testing for all training provided related to these transitions. Findings included:

- The IDTs made pre-move training recommendations related to each discipline assessment, which was positive, but did not include these requirements in the pre-move supports. For the most part, though, the pre-move training the Center provided did include much of this training. For example, the narrative recommendations prescribed training on behavioral supports and strategies. While no pre-move training support was developed, the Center staff did provide training in this area.
- As described in regard to indicator 1, the IDTs did not always identify the expected provider staff knowledge or competencies that would need to be demonstrated.
- As described in regard to indicator 2, the IDT did not provide the extensive training or competency testing for Individual #114's behavior supports consistent with training they identified as being needed at the Center.
- Competency testing did not clearly document provider staff had knowledge of all essential supports. The tests did not include questions for many supports. For example, Individual #48 had many instructions for staff to provide a safe dining experience,

but the testing did not address these in a comprehensive manner.

- Some competency tests did not consistently test knowledge in a serious manner. For example, two true/false questions for Individual #48 stated (1) group home staff to implement the communication strategies and (2) group home staff should ignore his communication dictionary. None of the testing provided for review required provider staff to identify any specific communication strategies or describe the purpose of the communication dictionary. Another asked who should group home staff refer to if his feeding and swallowing abilities changed; the two options were (a) licensed speech language pathologist or (b) his roommate.
- The IDT did not ensure all training had been appropriately modified for the community setting and consistent with the prescribed supports. For example, a competency quiz for Individual #114's PBSP asked staff to complete a multiple-choice question about when she would have assigned time to talk with staff each day. The options provided referred to vocational in the morning or at the dorm in the evening or afternoon. The CLDP did not include a support that required assigned times, even though perhaps it should have.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Neither CLDP met criterion as described below. It was positive the Center had modified its CLDP to include a discussion of this transition need, but the IDTs had not used it effectively in these instances. For example:

- For Individual #48, the CLDP template included a series of questions for the IDT to discuss, including whether such collaboration was needed, but the IDT did not provide responses.
- The IDT for Individual #114 agreed collaboration between the Center's psychiatrist and his community counterpart should take place to discuss and review monitoring of recent medication changes and to request that no changes to medications be made within the first six months after transition. Per the PMM reports, this collaboration did not take place. The CLDP ISPA also stated the IDT agreed the respective medical doctors should collaborate, but the IDT did not include this as a support.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. The Center also included a prompt for discussion of this transition need in its CLDP template, which was positive. The IDT did not provide evidence this need was fully addressed for Individual #48, but the IDT for Individual #114 did do so.

- For Individual #48, the CLDP included a prompt for the IDT to discuss whether any settings assessment was needed, but the IDT did not provide responses. The 14-Day ISPA cited several recommendations for environmental needs, including a walk-in shower with a minimal lip and ADA standard grab bars. It further stated a transfer bench or small bench in a bathtub should not be used and that the home should be one-level without sunken rooms. The Transition Log indicated the master bathroom had a tub that required a small step up. The log also documented the Transition Specialist asked the physical therapist (PT) if there were any concerns with the layout of the home for Individual #48 or if she felt she needed to visit in the home prior to his transition. The therapist responded she had no concerns with the layout. Per interview, the PT did not indicate any concerns or feel the need to visit the home. The available documentation did not indicate whether the issue of the tub, rather than shower, had been resolved.
- For Individual #114, the IDT agreed a PT should assess the home for proper ambulation and supports needed and the CLDP included this as a pre-move support. The 14-Day ISPA documented a concern about Individual #114's ability to bathe safely,

because the home she preferred only had bathtubs that would not accommodate her shower chair. The provider indicated they used a shower bench instead, but the CLDP supports indicated that Individual #114's adaptive equipment included a shower chair. Per the Transition Log, the Center PT did make an assessment of the home and requested some changes be made. The Transition Log further documented these changes had been made. Per interview, the PT also completed a follow-up visit to the home to confirm.

17. The CLDP should include a specific statement of the IDT considerations of activities SLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. 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 IDT included such a statement in the section entitled Community Living and both CLDPs met criterion.

- For Individual #48, it was positive the IDT developed an individualized plan in this area. Per the transition log, the IDT planned for him to have his overnight visit with Center direct care staff involvement, including staff to accompany him on his visit for the first full day in the evening and on the second day. The Transition Specialist also offered to complete a visit for few minutes every day of his visit to observe how was doing and report back to the IDT.
- For Individual #114, the IDT documented a discussion of this need and a rationale for why such activities were not necessary for her transition. They agreed this support was not necessary for Individual #114 because she adapted well to change and was looking forward to the move. Provider staff also noted that several of their day program and home staff had worked with Individual #114 in the past when she lived in the community.

18. LIDDA participation: These two CLDPs met criterion.

19. The PMSRs for both individuals were completed prior to the transition date. It is essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility, but the PMSRs for these two individuals did not accomplish this. Examples of concerns from this review included:

- The CLDP included minimal pre-move supports for pre-move training, and these did not meet criterion for ensuring that provider staff were competent for either individual, as described under indicators 1 and 2.
- Neither PMSR provided any evidentiary documentation to confirm pre-move supports were in place. Each requirement was checked off as in place, but did not describe how that was determined. For example, many pre-move supports required PMM visual verification as evidence to be obtained, and some required training rosters, but the PMSRs included no evidence (other than a checked box) to demonstrate the presence of the respective support. Just as with the PMM Checklists, the PMM should provide a succinct comment about the evidence relied upon to verify the support was in place.

Outcome 5 – Individuals have timely transition planning and implementation.	
Summary: Individuals at Rio Grande SC who were referred for transition received a lot of attention from the transition department. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	48	114							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1							

Comments:

20. Both CLDPs met criterion for this indicator.
    - Individual #48 was referred on 5/30/17 and transitioned on 10/13/17. This was within 180 days and met criterion. While timely overall, the Transition Log documented some lack of responsiveness by the IDT in its coordination with the APC's office. For example, on 7/27/17, the Transition Specialist met with the APC and asked for her assistance regarding requests that had been made to the QIDP for a follow-up ISPA with Individual #48's IDT to continue the transition process that had not taken place. Also, on 8/21/17, the transition specialist reported a meeting was held with the IDT to discuss his pending orders for surgery, but that neither the transition specialist nor APC received notice from a QIDP that the meeting had been scheduled. The Center should review this sequence of events to ensure any needed corrective actions have been taken to ensure effective collaboration in the future.
    - Individual #114 was referred on 11/17/16 and transitioned on 3/21/17. This was also within 180 days and met criterion

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 and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted within past two years, 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
PNA	Psychiatric Nurse Assistant
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