United States v. State of Texas

Monitoring Team Report

Rio Grande State Center

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Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
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 State Center for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

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 in the category of requiring less oversight. For this review, two additional indicators were moved this category, both in restraint management.

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.

Overall, the Center was only a few months into its transition to the State SSLC system. As a result, some protocols were newly in place, and some important management positions remained vacant. For instance, the Center had interim managers in the Center director, behavioral health services director, psychiatrist, medical director, vocational/day coordinator, incident management coordinator, and QAQI director positions.

<u>Restraint</u>
The overall usage of crisis intervention restraint showed a decreasing trend across the nine-month period (with none since 7/2/18), but overall, an increase compared with the previous nine-month period. Most of the crisis intervention restraints during the current period were with one individual. Also, some of the restraints occurred during a confirmed allegation of physical abuse.

Of note was the continued decrease in the frequency of usage of crisis intervention chemical restraint. Over the past three monitoring reviews, usage decreased from 34 occurrences to four occurrences during this period, with none since 3/29/18.

- Documentation of proper protocols for when crisis intervention chemical restraints were used, however, continued to not meet criteria. For the one chemical restraint in this review, there was no evidence of a pre-restraint consultation

with behavioral health services, and review of the restraint by behavioral health services and IMRT did not occur until nearly a month after the restraint.

During interviews, DSPs correctly responded to the Monitoring Team's questions about restraint implementation, reporting, and supervision.

An area for focus is ensuring that supports are in place to have reduced the likelihood of behaviors occurring that resulted in restraint. Examples observed during this review were absence of engagement, insufficient evidence of consistent PBSP implementation, and absence of consistent psychiatric treatment.

For the restraints reviewed, some improvement was noted with regard to nurses' timely initiation of vital sign assessments, as well as the documentation of injury assessments and findings. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and conducting follow-up assessments as individuals' needs dictate.

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.

Rio Grande SC was in the initial stages of developing the system of meetings that set the occasion for daily Center-wide integrated discussions. These were morning medical, unit report, and IMRT meetings. Support and direction from the Center director, Corpus Christi SSLC administration, and State Office will be needed going forward for these meetings to have the kind of active participation seen at some of the other Centers.

Peer to peer aggression occurred frequently at Rio Grande SC. Specific incidents were presented at morning unit report and IMRT meetings. The Center would benefit from a Center-wide plan to assess, measure, and address peer to peer aggression.

Other

The Center did not submit documentation to show that the Pharmacy and Therapeutics (P&T) Committee reviewed and acted upon the two Drug Utilization Evaluations (DUEs) completed. In addition, consideration should be given to completing DUEs for individuals residing in the Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD) program, as opposed to joint DUEs with the mental health program.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: Restraint usage decreased over this review period, though it was higher than during the previous review period. Some of this was due to restraints that occurred during a confirmed allegation of physical abuse. That being said, there were no crisis intervention restraints since 7/2/18, no crisis intervention chemical restraints since 3/29/18, and no occurrences of crisis intervention mechanical restraint or protective mechanical restraint for self-injurious behavior. Restraint reduction committee was active. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
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.	90% 9/10	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (November 2017 through July 2018) were reviewed. The overall use of crisis intervention restraint at Rio Grande SC showed a decreasing trend over the nine-month period, however, the overall usage of crisis intervention restraint was higher during this nine-month period than during the previous nine-month period. Some of this may be accounted for due to 12 restraints that occurred during a confirmed allegation of physical abuse that included multiple restraints in January 2018. Given the trend during the nine-month period, considering the confirmed allegation, and given no occurrence of crisis intervention restraint since 7/2/18, this sub-indicator will be scored positively. Similarly, the occurrence of crisis intervention physical restraint is scored positively because its trend parallels the overall usage of crisis intervention restraint. The average duration of a crisis intervention physical restraint, however, remained high, at about four and one-half minutes. The issue of discovered or unreported restraints, described in the previous report, was no longer a recurring problem at Rio Grande SC.

The usage of crisis intervention chemical restraint decreased over the past four nine-month review periods. That is, the usage decreased from 34 occurrences then to four now, during this review period; and there had been none since 3/29/18. This was a major accomplishment for Rio Grande SC. There were no occurrences of crisis intervention mechanical restraint and no usage of protective mechanical restraint for self-injurious behavior (PMR-SIB).

There was a decreasing trend in the number of individuals who had one or more crisis intervention restraints each month, and there was one non-serious injury reported during restraint application during the review period (however, see comments regarding documentation of nursing assessments of possible injuries).

There was little usage of non-chemical restraints or pretreatment sedation for medical or dental procedures. Usage of TIVA for dental procedures did not show a decrease.

Thus, Center 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; use of protective mechanical restraint for self-injurious behavior; injuries during restraint; number of individuals who had crisis intervention restraint; use of non-chemical restraints for medical/dental procedures; and use of pretreatment sedation for medical/dental procedures).

Restraint reduction committee met regularly and reviewed video of restraint incidents. The Monitoring Team recommends that center-wide data, such as the 12 sets of data discussed above, also be reviewed at restraint reduction committee periodically, such as once per month. Also, they should consider separating medical/dental pretreatment sedation from medical/dental non-chemical restraints.

2. Four of the individuals reviewed by the Monitoring Team were subject to crisis intervention restraint. A fifth individual, who received non-chemical medical restraint, was also included in this review. Of these, three received crisis intervention physical restraints (Individual #115, Individual #38, Individual #44), one received crisis intervention chemical restraint (Individual #61), and one received non-chemical medical restraint (Individual #36). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for two (Individual #115, Individual #38). The other five individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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

Summary: Documentation and implementation of restraint improved since the last review. Indicators 3 and 4 maintained high performance over the last three reviews and, therefore, will be moved to the category of requiring less oversight. With sustained high performance, indicators 5, 6, 7, 8, and 10 might be moved to this category, too, after the next review.

Individuals:

#	Indicator	Overall Score	115	38	61	44	36				
3	There was no evidence of prone restraint used.	100% 6/6	1/1	1/1	1/1	2/2	1/1				
4	The restraint was a method approved in facility policy.	100% 6/6	1/1	1/1	1/1	2/2	1/1				
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 5/5	1/1	1/1	1/1	2/2	N/A				
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 4/4	1/1	1/1	N/A	2/2	N/A				
7	There was no injury to the individual as a result of implementation of the restraint.	83% 5/6	1/1	1/1	1/1	2/2	0/1				
8	There was no evidence that the restraint was used for punishment or	100%	1/1	1/1	1/1	2/2	1/1				

	for the convenience of staff.	6/6									
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 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.	83% 5/6	1/1	1/1	0/1	2/2	1/1				
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	83% 5/6	1/1	1/1	0/1	2/2	1/1				

Comments:
The Monitoring Team chose to review six restraint incidents that occurred for five different individuals (Individual #115, Individual #38, Individual #44, Individual #61, Individual #36). Of these, four were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a non-chemical medical 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.

7. For Individual #36, the client injury report showed occurrence of a bruise due to the restraint. Although it was unfortunate that that occurred, it was good to see the Center recording this information.

9. Because criterion for indicator #2 was met for four of the individuals, this indicator was scored for them. For Individual #44, absence of a functional behavior assessment, engagement in activities, and consistent psychiatric treatment resulted in a 0 score.

10. Consultation with behavioral health services prior to the crisis intervention chemical restraint for Individual #61 was not done. Shortly thereafter, the Center put into place a protocol for ensuring proper pre-implementation consultations.

The medical/dental restraint plan for Individual #36 was well done and detailed.

11. Rio Grande SC now had a process for putting this information into the IRRF. For Individual #61, the information explained the contraindication, however, it did not explain how that affected/limited restraint implementation.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: The Monitoring Team interviewed six randomly chosen DSPs from both shifts. All correctly, though not identically, answered all questions. All seemed knowledgeable about restraint prohibitions, reporting, and supervision.			Individuals:								
#	Indicator	Overall Score									
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

	a set of questions.	
Comments:		

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: Performance on indicator 13 improved to 100% from 0% at the last review. This was good to see. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	38	61	44	36				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 5/5	1/1	1/1	1/1	2/2	N/A				
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									
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: For the restraints reviewed, some improvement was noted with regard to nurses' timely initiation of vital sign assessments, as well as the documentation of injury assessments and findings. Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and conducting follow-up assessments as individuals' needs dictate. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	38	44	61	36				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/6	0/1	0/1	0/2	0/1	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	67% 4/6	1/1	1/1	2/2	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.	17% 1/6	0/1	1/1	0/2	0/1	0/1				
Comments: The restraints reviewed included those for: Individual #115 on 1/13/18 at 3:53 p.m.; Individual #38 on 7/2/18 at 4:55											

p.m.; Individual #44 on 4/15/18 at 8:25 p.m., and 6/29/18 at 6:56 p.m.; Individual #61 on 3/29/18 at 2:57 p.m. (physical/chemical); and Individual #36 on 1/24/18 at 4:25 p.m. (medical restraint to obtain labs).

a. through c. For the following restraints, nurses conducted monitoring at least every 30 minutes from the initiation of the restraint, and monitored vital signs: Individual #115 on 1/13/18 at 3:53 p.m., Individual #38 on 7/2/18 at 4:55 p.m., Individual #44 on 4/15/18 at 8:25 p.m., and Individual #61 on 3/29/18 at 2:57 p.m. (physical/chemical).

The following provide examples of problems noted:

- An ongoing problem was the lack of detail regarding individuals' mental status. For example, many of the entries included statements such as: ""alert, oriented to time, place, and person."
- For Individual #44's restraint on 6/29/18 at 6:56 p.m., the Restraint Checklist indicated the nurse did not assess the individual until 7:40 p.m. An IPN, dated 6/29/18 at 11:51 p.m., noted the nurse saw him at 7:00 p.m., but no assessment was provided.
- For Individual #115's restraint on 1/13/18, discrepancies existed in the various restraint documentation regarding the start and stop time of the restraint. In addition, both the nursing IPN, dated 1/14/18 at 12:06 a.m., and the Client Injury report, dated 1/13/18, indicated that when the individual put a coin in his mouth to swallow it, a staff member "lock jaw, finger sweep to remove coin from his mouth." This action posed a number of risks, such as the possibility of breaking the individual's jaw, injuring the individual's mouth/teeth, precipitating a choking incident, the individual severely biting the staff member, and a risk of infection for both staff and individual.
- For Individual #61's restraint, the nurse did not indicate in the IPN whether or not the individual received the chemical restraint, the time it was administered, who administered it, or the site of the injection, and whether or not the individual was cooperative for the injection or had to be restrained for administration. In addition, the nurse did not indicate whether or not she conducted neurological checks for this individual who was hitting her head on the ground and hitting herself in the face and mouth. The PCP note, dated 3/29/18 at 3:45 p.m., noted the individual complained of a headache, and had right occipital swelling the "size of a walnut." In the nursing IPNs provided, nurses had not documented any follow-up on these concerns.
- For Individual #36's restraint on 1/24/18 at 4:25 p.m., according to the nursing IPN, dated 1/24/18 at 11:22 p.m., the nurse notified the PCP at 4:10 p.m. that the previous day, due to the lack of cooperation from the individual, the nurse could not obtain an in-and-out urine specimen (by catheterization) to determine the effectiveness of the treatment "done 2 weeks ago" [apparently, the individual was treated for a urinary tract infection (UTI)]. The note then indicated that the PCP ordered "a medical hold for in-and-out urine specimen." At 4:25 p.m., staff initiated a physical hold "to the arms, hands, legs to the client until 1635. Sterile in and out catheterization was done successfully." A previous IPN, dated 9:56 p.m. on 1/24/18, noted Individual #36 had redness to the posterior left shoulder, two bruises on her left lateral shoulder area, and a bruise to the right anterior thigh, but the note did not indicate if these were a result of her being held down earlier that day while being catheterized.

  A review of the Medical/Dental Restraint Plan indicated that Individual #36 had a history of sexual abuse at age 14. Although the Monitoring Team did not have access to this individual's entire record, holding an individual down to obtain a urinary sample poses significant risks, such as damage/tears to the urethra, urinary tract, and bladder; infection; as well as the trauma that it might cause a sexual abuse victim. The PCP note did not include any medical justification for the "medical hold" or indication that other alternatives were tried and failed, such as putting a hat in the toilet to collect urine, staff assisting in

collecting a clean catch, or conducting assessments for signs/symptoms of a UTI, or other interventions that would assist in assessing the success of the treatment. Also, the IPNs reviewed did not indicate how many staff participated in the hold; the size of the catheter; the amount, color, odor, and appearance of the urine collected; or that Individual #36 was assessed afterwards for any signs of mental trauma (e.g., sleep problems, nightmares, depression, crying episodes, self-injurious behaviors, inappropriate sexual behaviors) or physical trauma (e.g., blood in the urine, infection, pain while urinating).

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

Summary: This indicator returned to near 100% performance. However, the Center needs to attend to documentation regarding nursing assessments, especially regarding crisis intervention chemical restraint (see immediately above). This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	38	61	44	36				
15	Restraint was documented in compliance with Appendix A.	83% 5/6	1/1	1/1	0/1	2/2	1/1				

Comments:

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.

Summary: Review of crisis intervention chemical restraint did not occur as required, however, since then, the Center put a protocol in place. No crisis intervention chemical restraints have occurred since the one in this review. Indicator 17 improved to 100%. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	38	61	44	36				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	80% 4/5	1/1	1/1	0/1	2/2	N/A				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 5/5	1/1	1/1	1/1	1/1	1/1				

Comments:

16. For four restraints, the documentation described very good video review.

For Individual #61 3/29/18, the documentation (face to face form) showed review by the Unit/IMRT not until 4/25/18, a month after the restraint occurred. There was a good video review on 4/1/18 and a post restraint ISPA on 4/2/18. The Center acknowledged this problem and subsequently, put a protocol in place for all crisis intervention restraints.

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: Crisis intervention chemical restraint was now occurring infrequently, especially when compared to previous reviews. Two of the indicators were at criteria, but the third, regarding follow-up post restraint, was not occurring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	61								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1								
Comments: 47-48. These indicators applied to one individual, Individual #61. There was documentation of the post restraint review by psychiatry. In this restraint episode, one medication was utilized. 49. Review of the psychiatric documentation did not reveal psychiatric clinical follow-up after the chemical restraint. Individual #61 was next seen in psychiatry clinic approximately six weeks after the event, and the documentation did not note 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: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

	are followed.										
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. As discussed in the last report, 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. Until the Center is implementing improved 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. The following provides an example:

- On 5/3/18, while undergoing general anesthesia for dental work, Individual #108 experienced cardiac arrest. Per the ISPA, dated 5/4/18, her family reported: "hospital staff did not appear to know that [Individual #108] had a weak heart." The family also reported that hospital staff did not have records of when she was sent to hospital unresponsive one year prior.

  The PCP informed the family that: "her examination prior to sending [Individual #108] to the hospital was a good bill of health." The PCP further stated that she was started on hydrochlorothiazide (HCTZ) "at the request of the QDRR about a month ago." (Of note, the Clinical Pharmacist makes recommendations with which the PCP can agree or disagree based on their clinical appropriateness.) This individual had cardiac issues, and was seeing a cardiologist, but had never completed the recommended diagnostics. She had evidence of a low ejection fraction in previous years. This all underscored the need to complete a thorough perioperative assessment of individuals prior to the use of general anesthesia.

For this instance of general anesthesia, informed consent for was present, nothing-by-mouth status was confirmed, and post-operative vital sign flow sheets were submitted.

b. For Individual #21's oral pre-treatment sedation on 1/3/18, informed consent was not present. The Center also did not submit evidence to show that the dentist/PCP obtained input of the interdisciplinary committee/group, when determining the medication and dosage range.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/3	0/1	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A

Comments: a. A number of problems were noted, including:

- The Center did not submit evidence to show that the PCP used the input of the interdisciplinary committee/group, when determining the medications and dosage ranges for any of the three individuals.
- Informed consent was not provided for the pre-treatment medical sedation of Individual #108 on 2/26/18, or Individual #21 on 1/3/18.
- The Center did not submit pre- or post-procedural vital signs for Individual #103.

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: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:									
#	Indicator	Overall Score										
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.											
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.											
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 (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.											
4	Action plans were implemented.											
5	If implemented, progress was monitored.											
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.											
Comments:												

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: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	19	15	143	11					
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.	100% 4/4	1/1	1/1	1/1	1/1					

b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/3	N/A	0/1	0/1	0/1					

Comments: a. Since the last review, five individuals died. The Monitoring Team reviewed four deaths. At the time of the Monitoring Team's review, the Center's review and follow-up activities for Individual #79 were not complete. Causes of death were listed as:

- On 1/15/18, Individual #11 died at the age of 52 with causes of death listed as complication of constipation.
- On 3/5/18, Individual #143 died at the age of 62 with causes of death listed as septic shock, and recurrent complicated urinary tract infection.
- On 6/25/18, Individual #15 died at the age of 62 with causes of death listed as cardiopulmonary arrest, renal failure, and bilateral aspiration pneumonia.
- On 7/10/18, Individual #19 died at the age of 56 with cause of death listed as chronic respiratory failure.
- On 8/10/18, Individual #79 died at the age of 65 with cause of death listed as chronic respiratory failure.

b. through d. Evidence was not submitted to show the Center conducted thorough reviews of medical care, or an analysis of medical reviews to determine additional steps that should be incorporated in the quality improvement process. As a result, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews. For example:

- The PCP responsible for the provision of medical services completed the medical death reviews/discharge summary. This did not provide an objective assessment of the care provided.
- It was unclear who chaired the clinical death reviews. Overall, the findings and recommendations appeared to have been cut and pasted from the nursing death reviews.
- Although, as discussed in further detail below, the reviews addressing nursing care and services were comprehensive, the content was appropriately limited to the clinical areas addressing nursing, and should not be a substitution for a robust clinical medical review.

For individuals who have dysphagia and episodes of pneumonia/aspiration pneumonia (or other physical and nutritional management risks), a thorough review of staff's compliance with the PNMP should be completed as part of the mortality review process to determine whether or not breaches in the plan occurred. Based on the documentation provided, this had not happened.

On a positive note, the Quality Assurance (QA) Nurse completed comprehensive reviews that were summarized in well-organized

reports. The analysis of the clinical content and data that the QA Nurse completed generally supported the Findings and Recommendations included in the reports. Areas that the QA Nurse reviewed included the Functional Skills Assessments, skill acquisition plans (SAPs), QIDP monthlies, ISPA/IDT post-Emergency Department (ED)/Hospitalizations, IRRFs, IHCPs, Changes of Status, Acute Care Plans, Nursing Protocols, bowel movement tracking, and the Floor Nursing documentation.

For example, the QA Nurse completed an exceptional review and analysis of Individual #11's constipation, and the supports and services provided at the Center. This individual was a tragic example of the lack of staff's identification of a change in status, the lack of necessary and frequent nursing assessments, the lack of nursing staff and the IDT's review of health issues, a failure to address significant gaps in bowel movement data, in spite of the RN Case Manager initialing the bowel movement log on a daily or weekly basis, and the lack of the IDT's urgency in responding to known health and behavior issues. The QA Nurse made a number of important recommendations to address these issues.

e. Unfortunately, for the nursing recommendations, the Center did not provide any data to demonstrate that monitoring activities were implemented to determine whether or not the recommendations were effective (i.e., the intended outcomes were met). In addition, for each applicable individual (i.e., follow-up due dates for Individual #19 were after the document request production date), one or more recommendation did not have supporting documentation to show that the action steps were implemented.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the individual reviewed with an ADR, staff did not conduct proper reporting or follow-up. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	ADRs are reported immediately.	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/1		0/1							
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/1		0/1							
d.	Reportable ADRs are sent to MedWatch.	N/A		N/A							
Comments: a. through d. Individual #61 developed hyponatremia secondary to oxcarbazepine. The medication was discontinued in May 2018. In May 2018, staff reported the ADR. It was recorded as a Type B reaction. The Medical Director identified it appropriately as a Type A reaction, which is not an idiosyncratic reaction. The ADR form was incomplete, and the chairperson of the Pharmacy and Therapeutics (P&T) Committee had not signed it as required. P&T Committee meeting minutes were not 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: The Center did not submit documentation to show that the P&T Committee reviewed and acted upon the two DUEs completed. In addition, consideration should be given to completing DUEs for individuals residing in the ICF/IDD program, as opposed to joint DUEs with the mental health program. These indicators will continue in active oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	0% 0/2
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 Oxcarbazepine that was based on a sample of nine individuals. Three of the individuals were from the ICF/IDD program (i.e., 50% of the individuals in the ICF program that received the drug) and six were from the mental health (MH) program. The Center did not submit the requested information, such as data collection forms and P&T Committee meeting minutes. The DUE covered the quarter from December 2017 to February 2018. The Pharmacy Director reported that the DUE was not presented in the January P&T Meeting (she was caught in a snow storm), which was the quarter in which it was done, and the March meeting was cancelled. Reportedly, the DUE was presented in the June/July meeting (i.e., the Pharmacy Director could not remember the exact month), but minutes were not available at the time of the Monitoring Team's onsite review. The DUE included a statement that on 4/17/18, the Pharmacy Director completed data analysis. This was well after the DUE was due.

  The study generated a few recommendations. However, the Center submitted no documentary evidence that the DUE was discussed or that an action plan was generated based on the discussion and recommendations.
- A DUE on Clozapine was based on a sample of 17 individuals, seven of whom participated in the ICF/IDD program. The DUE covered the quarter from September 2017 to November 2017. The appropriate information was not submitted for review.

  Again, it was presented at the June/July meeting and minutes were not available. Therefore, documentation of the discussion, recommendations and action plans was not available.

The State should ensure that DUEs are appropriately completed based on State Office guidelines.

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, 11 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, three other indicators were moved to this category, in medical and communication. Two indicators, however, were returned to active monitoring, in psychiatry.

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

For most individuals, IDTs did not consider what assessments the individual needed and would be relevant to the development of an individualized ISP. Similarly, IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting.

Since July 2018, there was no psychiatrist onsite providing supports or services. A plan was in place for a psychiatric nurse practitioner from Corpus Christi SSLC to be onsite, though the number of days per week/month was still being determined. Due, in large part to the absence of psychiatry services, a number of psychiatry activities were not occurring or were now overdue. This included, for some individuals, completion of annual and quarterly psychiatric reviews. Some of the reports for the more recent reviews were not finalized, and many included handwritten notes in margins of draft documents.

In psychiatry, more than half of the individuals did not have a CPE. Some individuals did not have a CPE at the time of the last review, too. The CPEs that were done, however, were complete. Eight individuals required annual evaluations. One was done, and it had the complete content.

In behavioral health services, the Center's behavioral health services department was greatly understaffed for the past six months. That is, it went from having eight staff at the time of our last visit, to three staff as of this visit. As a result, performance in several areas declined from the last review, and some declined as a result of a planned reallocation of effort (e.g., to work on SAPs). These changes in the Center's performance should not be interpreted as a lack of effort or ability of the remaining three behavioral health services staff.

Behavioral assessments and functional assessments were generally timely, and complete. However, Individual #44 did not have a functional assessment and he presented one of the more challenging clinical cases at Rio Grande SC.

The behavioral health services data collection systems had improved since the last review, but there wasn't enough interobserver agreement activity to show that the data were yet reliable.

There were no data about the timeliness of FSAs, PSIs, or vocational assessments. Half of the individuals had FSAs and vocational assessments that included recommendations for skill acquisition plans.

Two individuals had no SAPs, and three individuals had one or two SAPs. All five of these individuals could have benefited from more skill training. Further, many of the SAPs that did exist scored low on being practical, functional, and meaningful.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), and/or use the risk guidelines when determining a risk level. 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.

On a positive note, for this review and the previous two reviews, Medical Department staff generally completed the medical assessments in a timely manner. As a result, the related indicator will be placed in the category requiring less oversight.

It also was good to see that clinical justification was present for most of the diagnoses reviewed. As a result of the Center's sustained performance in this area, the related indicator will move to the category of less oversight.

Although additional work was needed, the Center made progress with regard to the quality of medical assessments. Three of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history.

Improvement continued with regard to the timely completion of annual dental exams. The Center should continue its focus on completing timely annual dental summaries. Dental summaries were of poor quality, and the Center needs to continue to focus on the quality of annual dental exams as well.

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.

It was positive that as needed, a Registered Nurse (RN) Post-Hospitalization Review was completed for the individuals reviewed, and that in most instances, the PNMT discussed the results. As discussed in the last report, the Center should focus on the timely referral of individuals who meet criteria for referral to the Physical and Nutritional Management Team (PNMT), and the completion of PNMT reviews for individuals who need them. The quality of PNMT reviews and comprehensive assessments also continues to need work, particularly with regard to the completion of thorough assessments, review and analysis of relevant data to aid in the identification of underlying causes of PNM issues, and the development of recommendations to address the causes.

In previous reports, the Monitoring Team has expressed significant concern about the quality of Occupational Therapy/Physical Therapy (OT/PT) assessments and updates. During this review, no progress was noted. It is essential that the Center take steps to ensure that individuals' OT/PT strengths and needs are fully assessed and described in a way that is helpful to IDTs, current supports are assessed for efficacy and assessments identify any need for modifications to supports, and that recommendations to address individuals' needs are clearly articulated and justified. The Center's performance with regard to the timeliness of OT/PT assessments, and re-assessment based on changes of status also needs improvement.

Communication assessments included a number of positive components. However, work is needed to improve the quality of communication assessments and updates in order to ensure that alternative and augmentative communication (AAC) options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills; and coordination occurs between speech language pathologists (SLPs) and Behavioral Health Services staff.

Individualized Support Plans

Rio Grande SC showed good improvement in the percentage/number of personal goals that met criteria for individuality and measurability. This was the case for all goal areas, except for health/wellness. This latter goal area is a focus of State Office.

A focus on ensuring relevant data are collected is an important next step.

Teams should use ISP preparation meetings to prepare for the upcoming ISP meeting. The three-month period allows for conducting additional assessments, trying out some new activities, and so forth. The ISP Preparation meeting should not be treated as a mini-ISP meeting. That is, it is OK if goals are not identified at the ISP Preparation meeting and if, instead, team members decide to do further assessment and exploration to determine a meaningful personal goal.

Many personal goals did not have action plans that provided a path to eventually achieving the goal. Some goals had no related action plans, while others were only minimally or tangentially related to the achievement of the goal. In many cases, action plans that did exist had not yet been developed.

The Monitoring Team attended a SMART Goals meeting at the time of the last onsite visit and had been encouraged by the discussion about how to develop more measurable goals and objectives. It was good to see that, as a result, ISPs more often included specific service objectives to support IHCP goal areas. The Center continued to hold SMART Goals meetings, one of which was held during this onsite visit. The Monitoring Team was again impressed with the analytic approach of the members and the progress being made in the resulting goals and objectives.

At the Center, work opportunities had continued to be limited to shredding and bagging rocks, regardless of individuals' preferences and strengths. It was positive, however, that the Center reported several positive initiatives underway within the vocational program designed to provide individuals with more opportunities for meaningful work and learning.

Despite the positive developments described above, there had been no progress in the implementation of ISPs. The Center's staff were aware of this and had developed a plan to designate the lead QIDP to catch these up, but this was in the very early stages.

IDTs did not revise the ISPs as needed. The Center had also continued to have issues with timely QIDP monthly reviews since the last monitoring visit, although there was recent progress in that area.

Self-advocacy committee activities continued. During the onsite week, an election was held for officers of the committee. About two-thirds of the individuals attended the meeting/party. This level of participation was good to see.

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 physical and nutritional support interventions.

On a positive note, IDTs frequently defined the frequency of medical review in the IHCPs of the individuals reviewed.

Although significantly more work was needed, it was positive that some of the IHCPs reviewed included preventative nursing interventions, incorporated measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals, identified and supported the specific clinical indicators to be monitored, and/or identified the frequency of monitoring/review of progress.

Many improvements are needed with Physical and Nutritional Management Plans (PNMPs). With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

There were some individual-specific items the Monitoring Team identified for follow-up. This was shared with Center administration during the onsite week.

- Individual #44: He had refused medication since the end of June/early July 2018 when a court order had expired. He had exhibited some serious aggressive behaviors since then. The occurrences of medication refusal were not known to Center administration and were not included in presentations/discussions at morning medical, unit, and IMRT meetings. The Center was actively addressing this during the onsite week. Just prior to the submission of this report, the Monitoring Team learned that the court order had been resolved and re-instated in early October 2018.
- Individual #77: He was admitted to the hospital towards the end of the onsite week. The Center and IDT needed to re-visit his set of supports.
- Individual #30: There were different reports from various staff regarding whether he had graduated from public school or was going to be going back to school this year.
- Individual #103: His current medication regimen and medication history should be reviewed. He needed further assessment of his ability and safety in swallowing. There was some conflicting content in various assessments. Possible cardiac problems, and whether there were side effects from anti-psychotic medication needed to be explored. He also needed a more individualized daily schedule of activities.
- Individual #61: Her current medication regimen and medication history also needed review. She also needed a more individualized schedule of daily activities. There was also some question about barriers to her being able to visit with her grandmother.

In psychiatry, Rio Grande SC made progress regarding identifying psychiatric indicators for decrease and for increase.

In behavioral health services, PBSPs were implemented properly for more than half of the individuals, an improvement from none at the last review. PBSPs were current and complete for about three-quarters of the individuals.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: Rio Grande SC showed good improvement in the percentage/number of personal goals that met criteria for individuality and measurability. This was the case for all goal areas, except for health/wellness. This latter goal area is a focus of State Office support. A focus on ensuring relevant data are collected is another next step. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	103	61	150	77	68			
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	3/6	5/6	5/6	3/6	1/6	4/6			

2	The personal goals are measurable.	0% 0/6	3/6	4/6	5/6	3/6	1/6	3/6			
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	1/6	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 #115, Individual #103, Individual #61, Individual #150, Individual #77, and Individual #68. 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.

The IDTs continued to work toward developing measurable personal goals. For this review period, none of the six ISPs contained individualized and measurable goals in all areas, therefore, none had a comprehensive set of goals that met criterion. Still, this review found good progress had been made in developing personal goals that addressed individuals' preferences and strengths.

1. Twenty-one personal goals met criterion as aspirational statements of outcomes, based on an expectation that individuals will learn new skills and have opportunities to try new things that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live.

This was an improvement from the previous monitoring visit, when 13 goals met criterion. Findings included:

- It was positive that all six individuals had living options goals that reflected their preferences.
- It was positive that both Individual #103 and Individual #61 had personal goals that met criterion for leisure, relationships, work, and independence (i.e., five of six goal areas).
- Other personal goals that met criterion included:
  - Leisure goal for Individual #68.
  - Relationship goals for Individual #115, Individual #150, and Individual #68.
  - Work/day/school goal for Individual #68.
  - Independence goal for Individual #115 and Individual #150.

During the onsite week, the Monitoring Team attended the ISP Preparation meeting for Individual #97. There was some good discussion among attendees and the meeting facilitator did a good job of leading the meeting and, at times, challenging the team to come up with better goals. For instance, at one point, she said that a proposed goal was something the individual could do the next day, therefore, a more long-term meaningful goal needed to be developed. On the other hand, some proposed goals were carried forward

from the previous year after there was little/no implementation. The team should have had a deeper discussion of barriers to the current year's implementation. Also, the team struggled with coming up with a meaningful relationship goal. The Monitoring Team reminded the team that the ISP Preparation meeting was a forum to prepare for the ISP meeting. That is, they could use the time to come up with assessment-type activities so that they could be prepared for the ISP meeting in three months. For instance, there was some discussion about video calling with his family. The team could use the next few weeks to explore this (and other possibilities) and then come back together for a shorter meeting to report on findings. This input would then help to better inform the team in its determination of a meaningful relationship goal.

2. The Center also made good progress in the development of measurability when it came to personal goals. The Monitoring Team reviewed the 21 personal goals that met criterion for Indicator 1, and their underlying action plans as needed, to evaluate whether they also met criterion for measurability. Of these 21 personal goals, 19 met criterion for measurability. These were:

- Leisure goals for Individual #115, Individual #103, Individual #61, and Individual #68.
- Relationships goals for Individual #103, Individual #61, and Individual #150.
- Work/day/school goals for Individual #103, Individual #61, and Individual #68.
- Independence goals for Individual #115, Individual #61, and Individual #150.
- Living options goals for all six individuals:
    - All these goals were considered compliant based on an assumption that they were projected to be met within one to three years. That being said, five of the six individuals' goals had minimal or no action plans that were likely to result in their achievement, as described further below under Outcome 4.
    - The IDTs should be cautious about establishing living options goals without any plan for accomplishment. In other goal areas, IDTs tended to discontinue personal goals and establish new ones when they were not achieved, but this approach would not work well, or be appropriate in most instances, for living options.
    - To continue to meet criterion for compliance for measurability, living options goals will need to demonstrate they are not just statements of preference but also working goals.

3. For the 19 personal goals that met criterion in indicator 2, one had reliable and valid data. This was for Individual #115's living options goal. Otherwise, goals did not have measurable action plans and/or were seldom implemented.

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

Summary: Performance scores remained low on this set of indicators that looks at the overall ISP as a whole. That being said, there were some improvements seen in some of the areas, such as plans for vocational/day service options. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	103	61	150	77	68			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities	16%	1/1	0/1	0/1	0/1	0/1	0/1			

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

Comments:
As Rio Grande SC further develops more individualized personal goals, it is likely that action 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. Each personal goal must have measurable action plans, whether skill acquisition plans (SAP), service objectives for participation or for staff tasks (SO), or Integrated Health Care Plans (IHCP), that list the necessary steps to meet the personal goal. The action plans to achieve the goal should address what is hoped to be accomplished over the next year to meet each personal goal. If there is not a clear link between the action plans and the personal goal, there should be evidence in the ISP explaining how the action plans relate to the expectations for what is to be accomplished within the year. Action plans also need to be individualized based on the needs of the individual. As described under Outcome 1, it was positive that this group of individuals had many personal goals that met criterion. It was, therefore, equally unfortunate that many of those goals did not have assertive action plans that met the criteria described above. Some goals had no related action plans, while others were only minimally or tangentially related to the achievement of the goal. Moreover, in many cases, the projected action plans had not yet been developed. Examples included:

- Individual #61, Individual #150 and, Individual #68 did not have SAPs developed for any of the personal goals with action

plans for skill acquisition. The Monitoring Team could not assess whether those action plans would have met the criteria described above.

- Neither Individual #77 nor Individual #150 had any action plans for their living options goals.

9. One of six (Individual #115) ISPs contained a set of action plans that clearly integrated both preferences and opportunities for choice in an assertive manner. Otherwise, IDTs continued to demonstrate increased proficiency in developing action plans that integrated preferences, which was positive, but at the current time, offered minimal, if any, opportunities for choice-making.

10. None of six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. The IDTs had not developed such action plans for these six individuals. IDTs should consider that action plans that promote the ability to make choices can serve as stepping stones toward informed decision-making. Examples of missed opportunities for enhancing individuals' abilities to make informed choices included:

- Individual #115 had an active referral for community living, but had asked to move to Denton SSLC to be closer to his family. Until prompted by the Monitoring Team, the IDT did not consider living options action plans to ensure he was provided with all the information he needed to make an informed choice, such as the how long a transfer to Denton SSLC would take versus a potentially much shorter timeframe to transition to a community setting near his family. Also, the IDT had not followed up to obtain information from the Local Intellectual and Developmental Disabilities (LIDDA) about the option for shared living and/or a foster home that had been previously discussed.
- For Individual #61, the IDT did not identify any action plans in this area, even though her recent behavioral health root cause analysis (RCA) indicated at least one cause for increases in her challenging behaviors was making changes without her input. The RCA recommendations did not address this concern.
- Self-advocacy committee met during the onsite review week. This time, it was an election for officers. The meeting was attended by about two-thirds of the individuals (i.e., about 40). There was good engagement and a party-like atmosphere. Self-advocacy committee can be another forum/opportunity for individuals to learn to make decisions. These types of activities can be included in individuals' ISPs. The individual who was elected president was Individual #50. He was reviewed by the Monitoring Teams during previous reviews, at which times he was exhibiting frequent psychiatric and behavioral problems. It was good to see that he was able to successfully run for, and be elected to, this position.

11. None of six ISPs met criterion for supporting overall independence. The IDTs did identify some action plans to support independence, but did often did not address identified needs in this area in an assertive manner. In addition, many of the related SAPs and SOs had either not been developed and implemented or had inconsistent implementation. Examples included, but were not limited to:

- It was positive Individual #103 was receiving direct speech therapy, but the IDT did not integrate communication strategies into his action plans as recommended. The Functional Skills Assessment (FSA) identified many needs in areas such as toileting, dressing, toothbrushing, and grooming, but the ISP did not include related action plans.
- For Individual #150, it was positive that the IDT focused on activities of daily living (ADLs) that would support living with his family, who had complained that he did not rinse the soap out of his hair adequately. Unfortunately, the IDT had not developed the SAP to wash his hair. In June 2018, the IDT planned to discontinue the unimplemented SAP because it had determined he already had this skill. The QIDP was not able to articulate if the issue of complete rinsing had been assessed in this process. In

another example, his Preferences and Strengths Inventory (PSI) twice indicated that staff thought he would like to be able, and could likely learn, to use the telephone independently, which would have been a very practical skill and would also further support his relationship with his sister and family. This was not addressed with any action plans.

- For Individual #68, the IDT identified training opportunities at the Center that could include learning to cook in the vocational room and kitchen skills. The ISP narrative further indicated he could engage in community learning to shop and improve his money management skills, obtain and retain employment, cash his check, pay his bills, and ride the community bus. The ISP did not include action plans for any of these; instead, the only action plans for independence were related to swimming, without a rationale for how this would support his independence.

12. The Center had made some strides in the development of action plans that integrated strategies to minimize risk. The Monitoring Team attended a SMART Goals meeting at the time of the last onsite visit and had been encouraged by the discussion about how to develop more measurable goals and objectives. It was good to see that, as a result, ISPs more often included specific service objectives to support IHCP goal areas. Examples included SOs for walking and bike riding programs as well as SOs for safe dining. The Center continued to hold SMART Goals meetings, one of which was held during this onsite visit. The Monitoring Team was again impressed with the analytic approach of the members and the progress being made in the resulting goals and objectives.

Still, overall, the IDTs did not assertively address risk areas in a consistent manner. IDTs were slow to react to both ongoing and emerging risks and often did not take assertive action to assess and develop needed interventions. None of six ISPs met criterion. Examples of findings for this visit included:

- Individual #103 had sustained significant unplanned weight loss at the time of the previous monitoring visit in November 2017 and had been exhibiting side effects. The IDT had attributed both issues to psychotropic medications. After a hospitalization in December 2017, the IDT initiated a Physical and Nutritional Management Team (PNMT) referral for weight loss in January 2017 and made some adjustments to his medications. These actions, while positive, represented a delayed response on the part of the IDT and this continued to be the case. For example:
    - At the time of this monitoring visit, Individual #103 had been discharged from PNMT after a weight gain of more than 20 pounds, with criteria for reassessment if he lost three pounds within a month or two pounds for two consecutive months. The Monitoring Team reviewed his weight record, which indicated he had lost three pounds, from 137 to 134 pounds, between 7/1/18 and 8/1/18. The IDT did not initiate a referral for reassessment. This was particularly concerning because the weight loss reflected an overall downward trend since the beginning of June 2018 when he weighed 140 pounds. The Monitoring Team asked for a more recent weight; that weight, recorded on 8/23/18, was 132 pounds. A referral back to PNMT had not been made, nor had the PNMT acted on these data.
    - The IDT continued to cite concerns about side effects, including a negative impact on his swallowing abilities and frequent episodes of tachycardia, but had not taken an assertive or comprehensive approach to evaluating his medication regimen.
- While it was positive to see that the Center had begun to undertake root cause analyses (RCA), IDTs lacked proficiency in this process. For example, Individual #61 had frequent peer to peer aggressions and engaged in self-injurious behaviors. In discussions, IDT members frequently attributed these occurrences to pain related to her menses. She was being treated with hormonal therapy to limit her menstrual period to once every 90 days and with Midol for any suspected or reported pain. Despite these factors, the IDT had not evaluated this as a root cause in an assertive or comprehensive manner. She had not had

a gynecological consult to investigate the cause of the pain. The IDT also completed a RCA for increased falls and challenging behaviors on 6/16/18 that concluded her behaviors were likely caused by changes in her medications. The RCA did not address menstrual pain other than to list menorrhagia as a diagnosis, but included no action steps to further investigate this potential cause.

- Individual #77 sustained a serious injury after being beaten by another individual, which included blows and kicks to the body and head. The Center did not pursue an assertive course to determine if his subsequent increased seizure activity, falls from bed, involuntary urination, and other symptoms could be related to the head injury or to otherwise identify a root cause.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well-integrated, as also described throughout this report. In addition to the examples provided in #12 above, the IDTs did not assertively address other needs, such as the following:

- Individual #103's communication strategies were not effectively integrated into his ISP action plans. Per the ISP, his specific strategies were to be integrated into his SAPs and SOs. His SAP for making pudding did include a paragraph describing communication techniques, which was positive, but did not include a simple recipe picture or wordbook as recommended. His SOs indicated staff should use his communication strategies and dictionary when executing each objective, but did not provide any specific instructions describing how to do so effectively in that context.
- The IDT did not take assertive approach to maintain or improve Individual #77's ambulation status. Per his PSI, being able to walk was very important to him, but his mobility had decreased after his hospitalizations, with little intervention. Many staff reported not knowing he could walk. The physical therapist (PT) indicated she was working with him twice a week, but there was no related documentation and the QIDP stated she was not aware of this.

14. Meaningful and substantial community integration action plans were largely absent from the ISPs for these six individuals. Examples included:

- Despite some personal goals for community leisure and community work, the ISPs for Individual #103, Individual #61, Individual #150, and Individual #68 had no related action plans that included strategies for community participation or integration.
- Individual #77's sole community action plan was to purchase batteries and CDs once weekly, to support his love of music, but the IDT did not consider any action plans to attend musical events in the community. In addition, per his PSI, staff in his home indicated he would probably like to participate in a Spurs or Cowboys fan club, but the IDT did not develop any action plan in this area.

15. None of six ISPs considered opportunities and action plans for day programming in the most integrated setting consistent with the individual's preferences and support needs. Again, despite personal goals for community work, the ISPs lacked assertive action plans that provided a path to achievement or even exposed the individuals to any community work exploration. At the Center, work opportunities had continued to be limited to shredding and bagging rocks, regardless of individuals' preferences and strengths.

It was positive, however, that the Center reported several positive initiatives underway within the vocational program designed to provide individuals with more opportunities for meaningful work and learning. The Monitoring Team encouraged Center staff to maintain a focus in this area, in light of the Center's history with other proposed initiatives that were not followed through from one

monitoring visit to the next. The current initiatives included, for example:

- Creating several "client worker" job descriptions that were expected to offer individuals meaningful and paid work opportunities on campus that were beyond shredding and bagging.
- Developing an on campus setting to give individuals opportunities to learn laundry, cooking, and other independent/community living skills.
- Creating a second garden area for individuals interested in learning nursery skills.
- Creating a database for tracking SAPs and other action plans that were supposed to be implemented in the vocational/day setting.

16. None of the six ISPs included action plans that laid out substantial opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet individuals' personal goals and needs. ISPs often provided limited opportunities for learning and functional engagement and, even those, had often not been implemented.

17. The IDT did not consistently address barriers to achieving goals. Overall, IDTs did not effectively address barriers to community transition with individualized and measurable action plans as described below in Indicator 26 and did not consistently address barriers to lack of implementation of the ISP.

18. ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Many SAPs and SOs had not been developed and even those that had were often missing key elements. 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: Two indicators improved since the last review, and one remained at 100%. The others scored 0%. A focus area is conducting a thorough living options assessment. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	103	61	150	77	68			
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).	50% 3/6	1/1	1/1	0/1	1/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	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	100%	1/1	1/1	1/1	1/1	1/1	1/1			

	entire IDT, inclusive of the individual and LAR.	6/6									
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).	67% 4/6	1/1	0/1	0/1	1/1	1/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	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.	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. Three of six ISPs (Individual #115, Individual #103, Individual #150) included a description of the individual's preference for where to live and how that was determined. Those that did not meet criterion were:

- The IDT was not able to reliably describe the preferences for Individual #61 due to her lack of exposure to and awareness of community living options. She was not aware of different community setting options and had never toured group homes.
- Individual #77's ISP stated the IDT could not determine where he wanted to live, but it further documented that when pictures were presented during the annual community living options information process (CLOIP) interview by the LIDDA staff, he kept pointing to them and saying "yeah."
- For Individual #68, the ISP stated the CLOIP interview indicated he wanted to live at the Center, but later stated he said he didn't care where he lived as long as there was food. The IDT clearly needed to probe his preferences more thoroughly.

20, 25, 27. These indicators were not scored because none of these individuals had annual ISP meeting during this onsite visit.

21. None of six ISPs fully included the opinions and recommendation of the IDT's staff members. Findings included:

- Assessments often provided a statement of the opinion and recommendation of the respective team member. That being said, some important assessments were not available at the time of the ISP to provide the required opinions and recommendations.
- ISPs did not yet consistently include independent recommendations from each staff member on the team that identified the most integrated setting appropriate to the individual's need. For example, the ISP did not document the independent recommendations from the following:

- For Individual #61, the ISP did not document recommendations from nursing, psychiatry, the QIDP, or the Speech/Language Pathologist (SLP).
- The ISP for Individual #68 did not include an independent statement from vocational, psychiatry, behavioral, occupational/physical therapy (OT/PT), SLP, or dental.
- None of the ISPs included an independent statement from psychiatry, but all the individuals had psychiatric needs.

22. Six of six ISPs included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR. Thus, this indicator met criterion.

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:

- The ISP for Individual #115 did not provide any discussion of the factors resulting in his past failed placements and how those might be addressed.
- Individual #150's sister stated she would like to him to live in group home close to her or back home with her, but that she knew he couldn't because he lacked benefits. The IDT did not further explore the option of his returning to live with sister or discuss any action plans to pursue residency or citizenship.

24. Four of six ISPs (Individual #115, Individual #150, Individual #77, Individual #68) met criterion and 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 Individual #103 and Individual #61, the IDTs identified behavioral/psychiatric barriers. They did not also identify individual lack of awareness, but should have.

26. None of six individuals who were not referred at the time of the ISP had individualized, measurable action plans, with learning objectives or outcomes to address obstacles to referral. Findings included:

- IDTs did not specify learning or awareness outcomes or plans to collect data to evaluate awareness for any of the individuals for whom this was a barrier.
- Two individuals (Individual #150, Individual #77) had personal goals for community living, but no associated action plans.
- A third individual (Individual #61) had one action plan under living options, an SO to match clothing to the weather. The IDT provided no rationale as to how this would further her goal to live in the community near her grandmother.

28. None of six ISPs had individualized and measurable plans for education, as described above in Indicator 26.

29. Six of six individuals had obstacles identified at the time of the ISP. Individual #115 had subsequently been referred following the ISP annual meeting.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.	
Summary: Getting ISPs implemented remained a challenge that continued to be a barrier to individuals receiving the actions and supports identified in their ISPs.	Individuals:

Indicators 32 and 33 scored lower than at the last review and indicator 32 remained at 0%. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	115	103	61	150	77	68			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	50% 3/6	1/1	0/1	0/1	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.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

32. ISPs were not fully implemented on a timely basis, within 30 days of the ISP meeting, for any of six individuals.

33. Three of six individuals (Individual #115, Individual #150, Individual #68) participated in their ISP meetings.

34. One of six individuals (Individual #150) had an appropriately constituted IDT that participated in the planning process, based on their strengths, needs, and preferences. Examples included:

- The IDTs for Individual #115 and Individual #61 did not include psychiatry representation, but both had significant psychiatric needs.
- Per the attendance sheet, participation in the ISP annual meeting for Individual #103 did not include the Registered Nurse Case Manage (RNCM), the primary care provider (PCP), or the dietitian, but he had been losing weight and had other significant unresolved medical issues. The SLP did not attend, even though Individual #103 was receiving direct speech therapy. Vocational staff did not attend.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Both indicators scored lower than at the last review, and both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	103	61	150	77	68			
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.	20% 1/5	0/1	0/1	1/1	0/1	0/1	N/A			

36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting, for one of five individuals (Individual #61). Examples of those that did not included:

- The ISP Preparation documentation for Individual #115 did not specify a requirement for psychiatry, FSA, vocational, or nutrition assessments.
  - On a positive note, though, it was good the IDT had specific questions for OT/PT about gross and fine motor skills related to his employment goal.
- For Individual #150, the IDT indicated he would not need an OT/PT or SLP assessment because he didn't receive services from those disciplines. It is important for the IDT to be aware that assessments are completed, at least in part, to determine if needs have changed, rather than simply based on whether an individual has received services in the past.
- The IDT for Individual #77 requested an SLP screening, though his needs indicated the need for a more comprehensive assessment.

36. IDTs did not consistently arrange for and obtain needed, relevant assessments prior to the IDT meeting. None of six ISPs met criterion. For example:

- Individual #103 did not have an original comprehensive psychiatric evaluation (CPE) or an annual psychiatric assessment, despite critical needs in this area.
- Five of six individuals did not have an FSA completed until after the annual ISP meeting. These included Individual #115, Individual #103, Individual #61, Individual #150, and Individual #68.
- Individual #68 also did not have the CPE, behavioral health assessment (BHA), or PSI available for his ISP meeting.

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	115	103	61	150	77	68			
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:

This remained an area of significant concern. There had been no progress in ensuring the implementation of ISPs, with minimal implementation of action plans for any of these six individuals. In many instances, the SAPs and SOs had not yet been created. This was

attributable to staffing shortages in the behavioral health services department, which had been responsible for the development of SAPs. Programmatic staff were aware and had developed a game plan that designated the lead QIDP to catch these up, but this was in the very early stages. It remained to be seen whether it would result in any improvement.

37-38. IDTs did not revise the ISPs as needed, as evidenced throughout this section and others. For all individuals, most action plans for personal goals had been infrequently implemented, if at all. This reflected negatively on the role of the QIDP to ensure individuals received required monitoring/review and revision of treatments, services, and supports. The Center had also continued to have issues with timely QIDP monthly reviews since the last monitoring visit, although there was recent progress in that area.

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: 103	61	108	128	21	77	15	68	67
a.	The individual's risk rating is accurate.	22% 4/18	0/2	0/2	0/2	0/2	1/2	0/2	1/2	2/2	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.	44% 8/18	0/2	0/2	1/2	1/2	2/2	0/2	1/2	2/2	1/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #103 – falls, and medication side effects; Individual #61 – constipation/bowel obstruction, and gastrointestinal (GI) problems; Individual #108 – choking, and cardiac disease; Individual #128 – falls, and constipation/bowel obstruction; Individual #21 – dental, and choking; Individual #77 – falls, and seizures; Individual #15 – skin integrity, and constipation/bowel obstruction; Individual #68 – fractures, and choking; and Individual #67 – constipation/bowel obstruction, and choking].

a. The IDTs that effectively used supporting clinical data, and used the risk guidelines when determining a risk level were those for Individual #21 –choking; Individual #15 – skin integrity; and Individual #68 – fractures, and choking.

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 and/or update the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #108 – choking; Individual #128 – constipation/bowel obstruction; Individual #21 – dental, and choking; Individual #15 – skin integrity; Individual #68 – fractures, and choking; and Individual #67 – choking.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: Note that the Monitoring Team has revised the wording and sub-indicators for indicators 4, 5, and 6 in order to provide more guidance and specific feedback to the Centers. Rio Grande SC made progress in that, for all individuals, psychiatric indicators for decrease and for increase were identified. In fact, for two individuals (Individual #38, Individual #61), all sub-indicators for indicators 4, 5, and 6 were met for goals/psychiatric indicators for decrease (but not for goals/psychiatric indicators for increase; hence the 1/2 scores). Psychiatric goals/indicators for increase were identical for all individuals. With the changing of psychiatry supports (i.e., new providers, connected to Corpus Christi SSLC's psychiatry department), the Center should work towards meeting the requirements of this outcome as a foundation of their future work. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/9	1/2	1/2	1/2	0/2	1/2	1/2	1/2	1/2	1/2
5	The individual has goals related to psychiatric status.	0% 0/9	0/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/9	0/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments:
The scoring in the above boxes have a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.

4. Psychiatric indicators:
A number of years ago, the State proposed terminology to help avoid confusion between psychiatric treatment and behavioral health services treatment, although the two disciplines must work together in order for individuals to receive comprehensive and integrated

clinical services, and to increase the likelihood of improvement in psychiatric condition and behavioral functioning.

In behavioral health services positive behavior support plans (PBSPs), the focus is upon what are called target behaviors and replacement behaviors. These are the observable, measurable behaviors for reduction and for increase, respectively. They are hypothesized to be, for the most part, under operant control. A functional assessment is conducted to determine the variables that set the occasion for, and maintain, target behaviors (i.e., their function). Replacement behaviors are chosen to provide a functionally equivalent, more socially appropriate alternative to the target behavior. Replacement behaviors sometimes need to be taught to the individual. Many times, however, replacement behaviors are already in the individual's repertoire, in which case the task for the Center is to set the occasion for those replacement behaviors to occur, be reinforced, and maintained.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder.

Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SSLC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder.

The Monitoring Team looks for:

a. The individual to have at least one psychiatric indicator related to the reduction of psychiatric symptoms and at least one psychiatric indicator related to the increase of positive/desirable behaviors that indicate the individual's condition (or ability to manage the condition) is improving. The indicators cannot be solely a repeat of the PBSP target behaviors.
b. The indicators need to be related to the diagnosis.
c. Each indicator needs to be defined/described in observable terminology.

Rio Grande SC showed progress in this area in that all individuals had one or more indicators related to the reduction of psychiatric symptoms (4a) and these indicators were related to their psychiatric diagnosis or diagnoses (4b). For example, Individual #61 had a diagnosis of intermittent explosive disorder. Psychiatric indicators were identified as impulse and anxiety, which were to be monitored via rating scales. In addition, the indicators were fully described using observable terminology for eight individuals, that is, for all except Individual #103 (4c). For example, Individual #150 had an indicator of psychosis, which was described as "laughing to himself, talking to himself, saying that there are people in his room, and saying people are talking about him." Thus, eight of nine individuals met criteria for all three sub-indicators of this part of indicator 4.

All of the individuals had psychiatric indicators for increase in positive/desirable actions, too (4a). The indicators, however, were the same for all individuals: vocational attendance and outing attendance. Per the documentation, an individual could meet the requirements of the indicator by attending activities, which would indicate an interest in activities and socialization. There was no requirement for active participation. This can be misleading, as was seen in the case of Individual #127, for whom there was documentation of 100% attendance, but the rating scales for symptom indicators were showing increased symptom experience. Thus, psychiatric indicators for increase need to be more individualized and related to the psychiatric diagnosis (4b, 4c). Thus, all nine individuals met criteria with sub-indicator a, but not for b and c, for this part of indicator 4.

5. Psychiatric goals:
The Monitoring Team looks for:

d. A goal is written for the psychiatric indicator for reduction and for increase.
e. The type of data and how/when they are to be collected are specified.

At Rio Grande SC, there were goals written regarding psychiatric indicators for reduction for all individuals. Goals included the psychiatric indicator and a criterion (5d).

There were notations regarding what type of data were to be collected, specifically that incidents would be documented via rating scales. In two examples (Individual #38, Individual #61), there was documentation of the frequency with which rating scales should be performed or who was responsible for performing the assessment (i.e., criteria for 5d were met for two individuals).

With regard to goals written regarding psychiatric indicators for increase, all individuals had the same goal regarding vocational attendance and outing attendance (5d). These goals, however, were not individualized and looked for a percentage of time attended, without reference to what total amount of time was expected. Moreover, some individuals achieved 100% attendance, but continued to experience significant psychiatric symptoms, specifically Individual #38, Individual #61, and Individual #127. How data were to be recorded was not specified (5e).

6. Documentation:
The Monitoring Team looks for:

f. The goal to appear in the ISP in the IHCP section.
g. Over the course of the ISP year, goals are sometimes updated/modified, discontinued, or initiated. If so, there should be some commentary in the documentation explaining changes to goals.

At Rio Grande SC, psychiatric indicators/goals were incorporated into the Center's overall documentation system, the IHCP, for two individuals, Individual #38 and Individual #61, but for goals for decrease, not those for increase. There were no examples of goals for increase included in the IHCP. As such, they were not in the IHCP and, therefore, were not part of the ISP and QIDP monthly reviews.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically presented in graphic or tabular format for the psychiatrist. Data need to be shown to be reliable. Reliability assessments are often done by behavioral health services, residential, or psychiatry staff. In addition to using data regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

At Rio Grande SC, reliable data were not reported for psychiatric indicators. Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's senior administration.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: More than half of the individuals did not have a CPE. Some individuals did not have a CPE at the time of the last review, too. Therefore, indicator 12 will be returned to active monitoring. The CPEs that were done, however, were complete (indicator 14). Additional attention to the activities of indicators 15 and 16 is required. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
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	44% 4/9	1/1	0/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
14	CPE content is comprehensive.	100% 4/4	1/1	No CPE	No CPE	No CPE	1/1	No CPE	1/1	No CPE	1/1
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.	50% 1/2			0/1				1/1		
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	56% 5/9	1/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1	1/1

Comments:

12-13. Four individuals, Individual #115, Individual #38, Individual #44, and Individual #127 had a CPE. The other five individuals, Individual #92, Individual #30, Individual #103, Individual #61, and Individual #150, did not have a CPE.

14. The Monitoring Team looks for 14 components in the CPE. All of the CPEs included the required components. So, when the CPEs were performed, they were thorough evaluations.

15. For the two individuals admitted in the two years prior to the onsite review, both had an IPN documented by nursing and primary care on the day of admission. Individual #30 was admitted to the facility 10/21/16, there was no initial CPE, but an annual evaluation dated 11/17/17, so the CPE was not completed within 30 days of admission.

16. There were four individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #150, Individual #38, Individual #30, and Individual #92. The behavioral health documentation for Individual #92 and Individual #150 was out of date

and, therefore, not a current evaluation.

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

Summary: Performance remained about the same as at the last review. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
17	Status and treatment document was updated within past 12 months.	12% 1/8	0/1	0/1	1/1	0/1	0/1	0/1	N/A	0/1	0/1
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	12% 1/8	0/1	0/1	1/1	0/1	0/1	0/1	N/A	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	33% 3/9	0/1	0/1	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.	78% 7/9	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	44% 4/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1

Comments:

17. Eight individuals required annual evaluations. One, regarding Individual #30, was completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. The annual evaluation regarding Individual #30 contained all of the required elements.

19. None individuals requiring an annual CPE had one completed prior to the annual ISP meeting. The evaluation regarding Individual #30 was dated the same date as the ISP meeting. Three individuals had quarterly psychiatric clinical documentation dated within the 90 days prior to the ISP.

20. The psychiatrist attended the ISP meeting for seven of the individuals in the review group.

If the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

21. There was documentation in four examples that included the required elements. This was good to see. In the other five examples,

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

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

Summary: None of the individuals in the review group had a PSP, so the PSPs for two other individuals were chosen for review. One met all of the criteria; the other met some of the criteria. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	50% 1/2									

Comments:
22. PSP documents regarding Individual #95 and Individual #67 were reviewed. In both examples, psychiatric indicators that related to the diagnosis were documented. In both examples, there were instructions for staff regarding responding to and supporting the individual.

The example for Individual #67 provided a great deal of detail regarding how the indicators present for this individual.

The PSP regarding Individual #95 indicated issues with sleep, but there was no notation of data collection beyond the quarterly rating scales. In addition, the document did not describe how the indicators present for this individual.

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

Summary: Similar to the last review, not all medications had consent forms. Therefore, indicator 28 will be returned to active monitoring. Consent forms that were done, however, were complete and adequate. The content required by indicators 30 and 31 was present for one and two individuals, respectively. Indicators 29-31 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

30	A risk versus benefit discussion is in the consent documentation.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
28. Current medication consent forms were provided for all medications prescribed for seven individuals in the review group. Individual #115 did not have a consent form for Topamax, a medication that was being utilized for dual purpose to address seizures and psychiatric symptoms. The consent forms for Individual #92 were outdated.

29. The consent forms included adequate medication side effect information in all examples.

30. The risk versus benefit discussion was not included in the consent forms in eight examples. The consent forms for Individual #44 included a detailed risk versus benefit discussion and this was good to see. Individual #150 and Individual #61 also had individualized documentation regarding the risk versus benefit, but this focused on the behavioral challenges monitored by behavioral health, not on the psychiatric indicators.

31. The consent forms in two examples included alternate and non-pharmacological interventions.

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. The behavioral health services data collection systems had improved since the last review (see indicators 26-30), but there wasn't enough interobserver agreement activity to show that the data were yet reliable. Therefore, indicator 5 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
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:
3. Individual #115's replacement behavior (percentage of opportunities to touch others) was not measurable.

5. No individual 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 should be a priority area for improvement for the behavioral health services department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.

Summary: Criteria were met for most indicators for most individuals. Performance, however, slid from the last review, when all three indicators scored 100%. Importantly, Individual #44 did not have a functional assessment and he presented one of the more challenging clinical cases at Rio Grande SC. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
10	The individual has a current, and complete annual behavioral health update.	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1
11	The functional assessment is current (within the past 12 months).	67% 6/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1
12	The functional assessment is complete.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	N/A

Comments:
10. Individual #150's annul behavioral health assessment, dated 3/17, was complete but it was not current (written/revised in the last 12 months). Individual #30's annul behavioral health assessment was current, but not complete (missing information regarding his intellectual status).

11. Individual #44 did not have a functional assessment. Individual #150 (3/17) and Individual #92's (4/17) functional assessments were not current (written/revised in the last 12 months).

12. Individual #44 did not have a functional assessment. Individual #127's functional assessment did not address the potential role of access to tangible items maintaining his physical aggression. The other seven contained all of the required components.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: PBSPs were implemented properly for more than half of the individuals, an improvement from none at the last review. The other two indicators maintained about the same level of performance. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	56% 5/9	0/1	0/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
14	The PBSP was current (within the past 12 months).	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	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	0/1	1/1	1/1	1/1	0/1

Comments:

13. Individual #115's consents/approvals were obtained on 3/4/18, however, his PBSP was not implemented until 4/13/18. Individual #92, Individual #30, and Individual #127's PBSPs were implemented prior to attaining consents/approval.

Although Rio Grande SC continues to have work to do to ensure that there is documentation that all PBSPs are implemented within 14 days of attaining consents/approvals, this represents an improvement from the last review when no individuals had documentation that their PBSP was implemented within 14 days of obtaining all necessary consents/approvals.

14. Individual #92 (4/22/17) and Individual #150's (3/23/17) PBSPs were more than 12 months old.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan.

Individual #115, Individual #92, Individual #30, Individual #103, Individual #61, Individual #127, and Individual #150's PBSPs were complete.

For the other individuals: The training of replacement behaviors was confusing because the replacement behaviors were mislabeled in Individual #38's PBSP. Individual #44's replacement behaviors were not functional and there was no rationale why functional replacement behaviors would not be practical or possible. Additionally, Individual #44 did not have a functional assessment, so his PBSP was not based on a functional assessment.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.	
Summary: Both individuals who were referred for counseling were receiving counseling. It was good to see that this follow-up occurred. These indicators will	Individuals:

remain in active monitoring.											
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 2/2	1/1							1/1	
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A									
Comments: 24-25. Individual #150 and Individual #115 were referred for and were receiving counseling at the time of the onsite review. These individuals were seen for counseling outside of the Rio Grande SC behavioral health department, that is, they were seen at the Rio Grande SC mental health services program. Therefore, these treatment plans were not reviewed.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 11 – 100%, Round 12 – 100%, and Round 13 – 88%), Indicator b will move to the category requiring less oversight. 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, and then, that the PCP completes the reviews according to the schedule. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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.	88% 7/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	38% 3/8	0/1	1/1	0/1	1/1	0/1	0/1	0/1	N/A	1/1
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." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim reviews will need to occur											

more frequently.

At times, the IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines (i.e., Individual #21, and Individual #77). In other instances, the IHCPs identified a frequency, but the PCP did not complete the reviews according to the schedule.

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

Summary: Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 11 – 89%, Round 12 – 100%, and Round 13 – 94%), Indicator b will move to the category requiring less oversight. To improve the quality of annual medical assessments, Center staff should focus on obtaining thorough family histories for individuals with active family contact. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
a.	Individual receives quality AMA.	33% 3/9	0/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18	2/2	2/2	1/2	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.	50% 8/16	0/2	2/2	2/2	2/2	0/2	0/2	0/2	N/A	2/2

Comments: a. It was positive that three individuals' AMAs (i.e., Individual #108, Individual #21, and Individual #15) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments reviewed 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, pertinent laboratory information, updated active problem lists, and plans of care for each active medical problem, when appropriate. Most, but not all included childhood illnesses. Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history.

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 most of the diagnoses reviewed. The exception was that Individual #108's diabetes was not appropriately classified as Latent Autoimmune Diabetes of Adulthood (LATA).

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #103 – cardiac disease, and aspiration; Individual #61 – osteoporosis, and seizures; Individual #108 – cardiac disease, and diabetes; Individual

#128 – other: Down syndrome, and other: hypothyroidism; Individual #21 – other: Down syndrome, and constipation/bowel obstruction; Individual #77 – diabetes, and cardiac disease; Individual #15 – other: hypertension, and constipation/bowel obstruction; Individual #68 – diabetes, and other: hypothyroidism; and Individual #67 – infections, and constipation/bowel obstruction).

As noted above, at times, the ISPs/IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines. For half of the individuals reviewed, the PCP conducted quality periodic medical reviews.

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. On a positive note, IDTs frequently defined the frequency of medical review in the IHCPs of the individuals reviewed. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
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.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	78% 14/18	2/2	2/2	2/2	2/2	0/2	0/2	2/2	2/2	2/2

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 #103 – cardiac disease, and aspiration; Individual #61 – osteoporosis, and seizures; Individual #108 – cardiac disease, and diabetes; Individual #128 – other: Down syndrome, and other: hypothyroidism; Individual #21 – other: Down syndrome, and constipation/bowel obstruction; Individual #77 – diabetes, and cardiac disease; Individual #15 – other: hypertension, and constipation/bowel obstruction; Individual #68 – diabetes, and other: hypothyroidism; and Individual #67 – infections, and constipation/bowel obstruction).

b. Good improvement was seen with regard to IDTs defining the frequency of medical review in the IHCPs of individuals reviewed. These decisions generally appeared to be based on current standards of practice, and accepted clinical pathways/guidelines, given the severity of the individuals' level of risk.

Dental

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

Summary: Over this review and the last one, improvement was noted with regard to the timely completion of annual dental exams. If the Center sustains this progress, Indicator a.ii might move to the category requiring less oversight after the next review. The Center should continue its focus on completing timely annual dental summaries. Dental summaries were of poor quality, and the Center needs to continue to focus on the quality of annual dental exams as well. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1	N/A	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	75% 6/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1	N/A	1/1
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	0/1	0/1	1/1	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: b. One of the nine individuals reviewed had a dental exam that included all of the required components. It was good to see that all of the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Treatment provided/completed; and
- An odontogram.

Most, but not all included:

- Sedation use;
- A summary of the number of teeth present/missing; and
- Periodontal charting.

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

- The recall frequency; and
- A treatment plan.

c. All of the dental summaries reviewed included the following:

- Treatment plan, including the recall frequency.

Most, but not all included:

- Recommendation of need for desensitization or another plan; and
- A description of the treatment provided (i.e., treatment completed).

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

- Effectiveness of pre-treatment sedation;
- The number of teeth present/missing;
- Dental care recommendations;
- Dental conditions that could cause systemic health issues or are caused by systemic health issues;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.

Summary: Nurses should include fall assessments in quarterly nursing assessments, and ensure the timely completion of annual nursing assessments. The remaining indicators require continued focus to ensure nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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.	63% 5/8	1/1	0/1	1/1	0/1	0/1	1/1	1/1	N/A	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.	13% 1/8	0/1	1/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	42% 5/12	1/2	1/2	N/A	1/2	N/A	1/2	0/1	1/1	0/2

Comments: a. For some individuals, annual nursing assessments were not completed at least 10 days prior to the ISP meetings. A number of quarterlies did not include fall assessments.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #103 – falls, and medication side effects; Individual #61 – constipation/bowel obstruction, and GI problems; Individual #108 – choking, and cardiac disease; Individual #128 – falls, and constipation/bowel obstruction; Individual #21 – dental, and choking; Individual #77 – falls, and seizures; Individual #15 – skin integrity, and constipation/bowel obstruction; Individual #68 – fractures, and choking; and Individual #67 – constipation/bowel obstruction, and choking).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, for a few of the risk areas reviewed, nurses included status updates, including relevant clinical data (i.e., Individual #103 – falls, Individual #61 – constipation/bowel obstruction, and Individual #68 – fractures). Unfortunately, nurses had not analyzed this information, including comparisons with the previous quarter or year, and/or made 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 some examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- Based on a review of the IPNs, nursing staff were not reporting and assessing Individual #103's episodes of tachycardia and increased blood pressures. An IPN, dated 2/4/18, noted he had been referred to the clinic for findings of tachycardia noting an electrocardiogram (EKG), from 2/8/18, was normal. However, a 24-hour Holter Monitor noted tachycardia with prolongation of QT intervals greater than 450 milliseconds (ms) was 42%. The note indicated that: "He is at risk for developing long QT syndrome which can be fatal." (The author of this IPN did not include a title to identify the discipline). This same information was included in the PCP IPN, dated 2/13/18, and noted that the timing of the psychotropic medications "do appear to correlate with client's bradycardia and tachycardia episodes. What concerns me most is his QTc interval."
- The episode tracker noted that on 6/18/18, Individual #61 received a suppository, but no nursing IPN was found documenting an assessment of this episode of constipation.
- An IPN, dated 4/5/18 at 5:30 a.m., indicated that Individual #128 had not had a bowel movement since 4/2/18. It noted that the nurse gave the individual 5.5 ounces of prune juice. However, the nurse did not conduct and/or document an assessment

to indicate if bowel sounds were present, to describe findings from palpation of the abdomen, to provide a set of vital signs, or to describe the individual's fluid intake, pain, or activity level.

- An IPN, dated 8/20/18 at 2:28 p.m., noted that Individual #77 slid down in his wheelchair twice, hit the back of his head against the counter, and was rolling on the floor on his back. The note also indicated that since 7:00 a.m., he had been upset. Although the note indicated Individual #77 was refusing an assessment, the nurse included no objective assessment in the note, regarding, for example, his respirations, ability to walk, status of his gait, pain assessment, level of consciousness, functioning, or activity.
- For Individual #15, the nurse who administered an enema on 6/14/18, due to complaints of pain and an increase in abdominal girth (i.e., from 95 centimeters to 100 centimeters) did not conduct and/or document an assessment in an IPN.
- For Individual #67, the Center did not submit an IPN addressing a medication change, specifically the initiation of Miralax daily, on 6/27/18. Also, on 7/27/18, prior to the administration of a pro re nata (PRN, or as needed) suppository, the nurse did not document bowel sounds, which is a part of the basic assessment criteria for constipation.
- An ISPA, dated 7/11/18, noted an increase in Individual #67's tardive dyskinesia (TD) mouth and head movements. No nursing IPNs were found addressing the increase in movements. An IPN, dated 7/12/18, noted Vitamin B6 was given and noted no "s/s [signs and symptoms] of ADR [adverse drug reaction] noted." However, based on the documentation, the nurse did not know the order was initiated due to his increase in TD movements. Consequently, the nurse conducted no assessment of his movements at that time. Also, the nursing physical assessment, conducted on 7/19/18, made no mention of the presence or absence of abnormal movements, which would have been an essential finding for this individual.

The following provide a few of positive examples of nurses conducting assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 2/3/18, Individual #103 fell. Throughout the day, nurses conducted assessments consistent with applicable standards.
- For Individual #61, on 7/10/18, in an IPN, a nurse documented a comprehensive assessment for an episode of vomiting.
- In response to Individual #128's fall, an IPN, dated 6/26/18, documented a nursing assessment that was consistent with applicable standards.
- For Individual #77, on 3/23/18 at 2:22 p.m., a nurse documented a complete assessment regarding a seizure.
- A nurse documented a thorough nursing assessment in an IPN, dated 5/16/18, of Individual #68's left shoulder pain, which was later diagnosed as a fracture.

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 Center's status with regard to the nursing content of IHCPs remained approximately the same as during the last review. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	protocols or current standards of practice.										
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	39% 7/18	0/2	1/2	1/2	2/2	0/2	1/2	0/2	1/2	1/2
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	1/2	2/2	0/2	1/2	0/2	1/2	1/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	44% 8/18	0/2	1/2	1/2	2/2	0/2	1/2	1/2	1/2	1/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	22% 4/18	0/2	1/2	1/2	0/2	0/2	0/2	0/2	1/2	1/2
Comments: Although significantly more work was needed, it was positive that some of the IHCPs reviewed included preventative nursing interventions, incorporated measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals, identified and supported the specific clinical indicators to be monitored, and/or identified the frequency of monitoring/review of progress. The following IHCPs scored the highest: Individual #61 – constipation/bowel obstruction; Individual #108 – cardiac disease; Individual #128 – falls, and constipation/bowel obstruction; Individual #77 – falls; Individual #68 – fractures; and Individual #67 – constipation/bowel obstruction.										

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.										
Summary: It was positive that as needed, a Registered Nurse (RN) Post Hospitalization Review was completed for the individuals reviewed, and that in most instances, the PNMT discussed the results. As discussed in the last report, the Center should focus on the timely referral of individuals who meet criteria for referral to the PNMT, and the completion of PNMT reviews for individuals who need them. The quality of PNMT reviews and comprehensive assessments also needs work, particularly with regard to the completion of thorough assessments, review and analysis of relevant data to aid in the identification of underlying causes of PNM issues, and the development of recommendations to address the causes. These indicators will remain in active oversight.			Individuals:							
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67

a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	0% 0/7	0/2	0/1	N/A	N/A	N/A	0/1	0/1	0/1	0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	29% 2/7	1/2	0/1				1/1	0/1	0/1	0/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	50% 1/2	1/1	N/A				0/1	N/A	N/A	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	57% 4/7	2/2	0/1				1/1	0/1	1/1	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	83% 5/6	1/1	N/A		1/1		1/1	1/1	1/1	0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/7	0/2	0/1				0/1	0/1	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	0% 0/5	0/1	0/1				N/A	0/1	0/1	0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/2	0/1	N/A				0/1	N/A	N/A	N/A

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

- For Individual #103, according to the RN quarterlies and the IRRF, the first evidence of weight loss greater than 10% occurred between June 2017 (131 pounds) and 11/17/17 (111 pounds) with weight loss continuing to 107 pounds (i.e., on 12/13/17), although some weights varied depending on the source. For example, the PNMT review cited weight loss of 10 pounds in one month (11/3/17 = 121 pounds to 11/29/17 = 111 pounds). It was difficult to determine when the IDT referred him to the PNMT. The PNMT meeting notes, dated 12/5/17, stated that formal referral was pending. On 12/12/17, PNMT notes indicated that they had not received a formal referral from the IDT, but they completed the review on that date. It was not clear why they did not move forward with a review within five days after the meeting held on 12/5/17. In addition, the PNMT should have initiated a review earlier in November to address the 10% weight loss in a six-month period in a timelier manner.

  The PNMT review cited a number of medication side effects and medication adjustments that the PCP and psychiatrist made as

potential causes for the weight loss. The PNMT indicated that his intake was generally 100% over the months preceding his weight loss. However, the PNMT did not use data to correlate the weight loss with the medication changes, so it remained unclear whether or not they were the underlying cause of the weight issues. In addition, the PNMT provided very little discussion of his current diet plan.

- From 12/13/17 to 12/29/17, Individual #103 was hospitalized for "healthcare associated pneumonia" and volume depletion. On 1/4/18, a modified barium swallow study (MBSS) indicated severe dysphagia and silent aspiration. Records identified aspiration associated with pneumonia. His IDT previously rated him at high risk for choking/aspiration due to head hyperextension, but documentation indicated that based on an MBSS that he was "safe" in this position, so they permitted him to hyperextend for drinking. Prior to December 2017, he reportedly had no previous history of aspiration-related illness. On 12/29/17, the PNMT RN completed the post-hospitalization review, and stated that due to the diagnosis of possible aspiration and undetermined weight loss, she recommended referral to PNMT for further assessment. However, it was not until 1/9/18, that the referral occurred.

  On 1/30/18, the PNMT completed an assessment. Concerns related to the quality of the assessment are discussed below.
- Although fall data was not reliable, records indicated that Individual #61 fell four times in March 2018, six times in May 2018, once in July 2018, and six times in August. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a minimum according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. Over several months, this individual's falls continued to place her at significant risk of harm. At a minimum, the PNMT should have conducted a review.
- On 4/27/18, Individual #77 was referred to the PNMT for unplanned weight loss, occurring between 4/2/18, when he weighed 141 pounds, and 4/19/18, when he weighed 129.5 pounds. This was reported as a 9%-loss in one month (i.e., but was actually an 8% loss). The referral date varied depending on the source. Between 4/3/18, and 4/17/18, he was hospitalized, and refused to eat much of the time. Reportedly, three days into the hospitalization, he developed aspiration pneumonia. Staff reported that his positioning in the hospital was very poor. The PNMT report did not describe aspiration pneumonia as a reason for referral, but there was reference to it in meeting minutes.

  Although the PNMT initiated an assessment within five days of the referral, it was not until 6/12/18, that the PNMT completed the assessment. He had subsequent hospitalizations with the last discharge on 5/24/18, with seven to 10 days in between each of three consecutive admissions. The PNMT did not provide adequate rationale for not completing the assessment for nearly three weeks after the last hospital discharge, though.
- On 5/15/18, at around 5:45p.m., Individual #68 fell and sustained an injury to the left arm. Shortly after midnight, based on x-ray results, the PCP was notified that the individual had a humeral fracture. On 5/31/18, the individual had an ORIF done on his left shoulder and returned to Center. It was not until 7/11/18, that the PNMT RN conducted a review. Although on 6/12/18, the PNMT indicated it would conduct a review, it appeared that the PNMT RN was the only one involved in the review of this long-bone fracture.
- For Individual #67, it did not appear that the PNMT conducted a formal review, which would have assisted in clarifying the supports he required to minimize his risk. On 2/1/18, the PNMT RN conducted a post-hospitalization review for his admission from 1/26/18 to 1/27/18 for acute vomiting. He was treated for a GI-intra-abdominal infection. The PNMT RN stated that he

would benefit from remaining upright after meals and snacks, which was not in his PNMP, so the RN's recommendation was to add this instruction. However, the following disjointed events resulted in a lack of clarity with regard to identifying the supports he needed:

- On 2/1/18, the PNMT RN indicated that he did not need a hospital bed, but should remain upright after meals.
- Sometime later that day, she indicated the he should have a hospital bed with head-of-bed elevation (HOBE) at 30 degrees.
- The same day, the PNMT PT conducted a HOBE evaluation, and concluded that he did not need a hospital bed.
- Also, later that day, an additional PT note stated that the PT had spoken to the PNMT RN and SLP, and decided that he should have a hospital bed, though no HOB elevation was recommended at the time.
- A PNMP, dated 2/5/18, added a hospital bed at 30-degrees elevation at all times, although it provided no instructions for the individual to remain upright after meals and snacks.
- On 2/23/18, Habilitation Therapies staff changed the PNMP HOB elevation to 20 degrees and added remaining upright for 45 minutes to one hour after meals and snacks.
- Neither PNMP included triggers for aspiration and neither identified GI as a risk area.
- Per an MBSS, dated 4/7/17, he had mild oral phase dysphagia and moderate pharyngeal dysphagia. If he remained upright after meals he "may not need a hospital bed." An additional note on the same date identified two vomiting episodes occurring in bed hours after supper. The notes indicated the emesis was large and undigested, and the individual complained of pain after vomiting. They also indicated he had a diagnosis of cholelithiasis (i.e., gallstones), which might re-occur. These notes indicated that he might benefit from a hospital bed with HOBE at least 30 degrees to mitigate risk of aspiration.
- By 4/17/18, the PNMP identified signs and symptoms for aspiration, but still made no reference to GI risk. Supports for elevation remained at 20 degrees at all times and instructed staff that he should remain upright after meals as previously stated.
- However, the IRRF, dated 4/17/18, stated that HOB elevation should be 30 degrees. The same IRRF narrative cited the PNMP with HOB elevation listed at 20 degrees.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments.

e. It was positive that for the most part, a RN Post-Hospitalization Review was completed for the individuals reviewed, and the PNMT discussed the results. The exception was for Individual #67, for whom, as discussed above, it did not appear the PNMT was involved in the review.

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

- As discussed above, on 1/4/18, an MBSS indicated that Individual #103 had severe dysphagia and silent aspiration. However, in conducting the assessment, the PNMT did not identify aspiration as the issue, but rather healthcare-associated pneumonia, MBSS findings, and weight loss. The PNMT assessment did not address the individual's medical history and current status related to PNM needs. It addressed weight loss and indicated that aspiration pneumonia was a potential contributing factor, rather than addressing the underlying causes of the aspiration pneumonia. For example, it provided no discussion of the

etiology of aspiration pneumonia or the aspiration.

- For Individual #77, it was not clear that the PNMT considered aspiration pneumonia as a presenting problem. Although the assessment listed the individual's medical history, the PNMT provided no discussion of its impact on and relationship to the presenting issues and PNM needs. Similarly, the assessment included a list of the individual's medications and medication changes, but again provided no discussion of the potential impact on the PNM issues. The PNMT did not include a discussion of the individual's target behaviors and their impact on PNM concerns and supports. The assessment reiterated IPNs, rather than providing a concise meaningful review of systems, making the assessment difficult to follow. Similarly, the PNMT assessment did not include a concise discussion of the individual's current supports and their effectiveness related to the primary issues and how necessary changes impacted him. The PNMT listed a number of issues that potentially related to the cause of his problems, but did not discuss how they correlated to each other, including data to support conclusions (e.g., the PNMT essentially attributed weight loss and aspiration to multiple hospitalizations, and then attempted to identify why he "landed in the hospital"). The recommended goals were not clearly justified or related to the etiology of the problems. For example, according to the PNMT ISPA, dated 6/12/18, the agreed-upon goal was: "Will remain upright with neutral head position while participating in an activity for at least 15 minutes twice daily x3 months." The PNMT did not specifically provide a rationale for this goal, for example, related to his overall weakness post-hospitalization and weight loss. They should have discussed his endurance in the upright position, fatigue during meals that could increase his chance of further aspiration, weight loss if he did not eat his meal, etc.

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. Many improvements are needed with PNMPs as well. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	22% 4/18	0/2	0/2	1/2	0/2	1/2	1/2	0/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2

f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: weight, and aspiration for Individual #103; aspiration, and falls for Individual #61; choking, and falls for Individual #108; choking, and falls for Individual #128; choking, and falls for Individual #21; aspiration, and weight for Individual #77; falls, and aspiration for Individual #15; choking, and fractures for Individual #68; and aspiration, and choking for Individual #67.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exception was for weight for Individual #77.

b. Overall, ISPs/IHCPs did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were the IHCPs for choking for Individual #108, choking for Individual #21, weight for Individual #77, and choking for Individual #68.

c. All individuals reviewed had PNMPs and/or Dining Plans. A number of problems were noted with the PNMPs and/or Dining Plans reviewed.

- It was positive that all of the PNMPs, as applicable to the individuals' needs:
  - Were reviewed and/or updated within the last 12 months; and
  - Provided descriptions of assistive/adaptive equipment.
- As applicable to the individuals, most, but not all of the PNMPs reviewed included:
  - Transfer instructions;
  - Mobility instructions;
  - Toileting/personal care instructions;
  - Medication administration instructions; and
  - Oral hygiene instructions.
- The components of the PNMPs on which the Center should focus on making improvements include:
  - PNMPs/Dining Plans need to list all of the individuals' risks and identify related triggers;
  - All PNMPs/Dining Plans included pictures that were difficult to see, because of their size, and they were not in color;
  - Positioning instructions – when an individual is independent, the PNMP should state that this is so;
  - Bathing instructions – PNMPs need to describe the level of support the individual needs;
  - Handling precautions or moving instructions – for individuals with osteoporosis, the PNMPs should describe the necessary precautions;
  - Mealtime instructions – problems varied, but some areas on which the Center should focus include defining head position, indicating the level of independence, and providing bite-size instructions; and
  - Including complete communication strategies.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

e. The IHCP that identified the necessary clinical indicators was for falls for Individual #21.

f. The IHCPs reviewed did not identify triggers and actions to take should they occur.

g. Often, the IHCPs reviewed did not include PNMP monitoring, or the frequency was not sufficient to address the individual's level of risk. The exceptions were for choking for Individual #128; and choking for Individual #67.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	N/A									
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	N/A									
Comments: a. and b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed received total or supplemental enteral nutrition.											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.	
Summary: In previous reports, the Monitoring Team has expressed significant concern about the quality of OT/PT assessments and updates. During this review, no progress was noted. It is essential that the Center take steps to ensure that individuals' OT/PT strengths and needs are fully assessed and described in a way that is helpful to IDTs, current supports are assessed for efficacy and assessments identify any need for modifications to supports, and that recommendations to	Individuals:

address individuals' needs are clearly articulated and justified. The Center's performance with regard to the timeliness of OT/PT assessments, and re-assessment based on changes of status also needs improvement. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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.	44% 4/9	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	67% 6/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal	N/A									

	comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/3	N/A	0/1	0/1	N/A	N/A	0/1	N/A	N/A	N/A

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

- On 12/5/17, the OT/PT completed Individual #103's update for an ISP meeting on 12/14/17. It should have been completed on or before 11/30/17.
- Although Individual #61 had a timely update for her ISP meeting, no evidence was found that the PT completed an update or evaluation for the at least five falls she experienced between 5/28/18 and 8/23/18.
- Individual #77 had a timely update for his ISP meeting. However, from 4/3/18 to 4/17/18, he was hospitalized, and the related ISPA stated that the OT/PT would evaluate him within one week. From 4/27/18 to 5/11/18, and 5/18/18 to 5/24/18, he had subsequent hospitalizations with no documentation from either the OT or PT regarding why assessments were not performed in between the hospitalizations. The cover sheet for the document request stated that before the evaluation on 7/27/18, the PT made attempts (i.e., it was unclear of what the attempts consisted) on the following dates: 4/26/18, 5/23/18, 6/14/18, 6/18/18, 7/3/18, 7/6/18, and 7/11/18. No documentation was submitted to substantiate PT activity for these dates. An OT IPN, dated 6/7/18, stated that he would assess the individual when he was more stable. The Center submitted no further documentation showing evidence that this occurred. On 6/8/18, the PT wrote an IPN stating that she had observed Individual #15 on 5/24/18, 5/30/18, 6/5/18, 6/6/18, and 6/7/18, but again no documentation on these dates described her findings. She stated that she would monitor him weekly and would initiate PT when he was ready. The Center submitted no evidence of this weekly monitoring. No further PT notes were found until nearly two months later, on 7/27/18, when the PT wrote an "assessment" note. The goals were outlined in that note. Based on the documentation submitted, the OT/PT did not complete a comprehensive change-of-status assessment.
- From 1/7/18 to 1/16/18, Individual #15 was hospitalized for Influenza A and community-acquired pneumonia. On 2/6/18, three weeks after discharge, the OT/PT completed a change-of-status assessment. They provided no rationale for the delay.
- On 5/7/18, Individual #68 was admitted to the Center. On 6/5/18, the OT and PT finalized a comprehensive evaluation, which was timely. On 6/6/18, an OT IPN note indicated that it was an "assessment to initiate direct OT per MD order." The IPN did not constitute an assessment.

d. and e. The Monitoring Team reviewed comprehensive OT/PT assessments for seven individuals, and updates for three individuals. As stated in the last report, "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." The following summarizes some of the many problems noted:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs: Often, the assessments merely listed diagnoses and identified health issues in last year, but provided limited to no discussion of their relevance to functional performance or support needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services: Individuals'

preferences generally were not reflected in the development of skills;

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Often, the assessments did not identify the individuals' full set of risks pertinent to OT/PT supports. In addition, a number of discrepancies were identified within the risk sections and between the risk sections and other sections of the assessments (e.g., Individual #67's assessment did not address his risk for choking, but then stated his supports for choking were effective, because he had not choked, but later stated that in the past year, he had a choking event requiring use of the abdominal thrust);
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services: For most individuals, the assessors did not discuss whether or not medications were potentially impacting an OT/PT problem(s);
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living (ADLs): Many assessments offered incomplete information about individuals' fine, gross, sensory, and other motor skills, as well as ADLs. Descriptions such as "poor" or "fair" skills were not helpful or functional descriptions;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): For applicable individuals, often, discussion of wheelchair condition was not included in the assessments. Fit also was not discussed, nor was a rationale for components provided;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments: Most assessments reviewed did not provide a comparative functional analysis;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings: None of the assessments met this criterion. Problems included a lack of monitoring findings, and/or a lack of discussion about and/or revisions to supports that were not effective at minimizing or preventing PNM issues, such as falls, etc.;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: A number of assessments identified OT and/or PT needs for which supports or services were not recommended, but clinical justification was not offered for not making such recommendations. Similarly, some assessments recommended services, but did not provide the rationale; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations that should have been made to address individuals' needs were not.

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: It was good to see that the ISPs for most individuals reviewed outlined the IDTs' review of the PNMPs and the modifications required. The ISPs then stated the PNMPs were approved with these modifications. Improvement is needed with regard to the remaining indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.	Individuals:

#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1	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.	0% 0/7	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	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% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	0/1	N/A

Comments: a. The ISPs reviewed did not include concise, but thorough descriptions of individuals' OT/PT functional statuses. Therapists should work with QIDPs to make improvements.

b. The ISPs for most individuals reviewed outlined the IDTs' review of the PNMPs and the modifications required. The ISPs then stated the PNMPs were approved with these modifications. The ISPs that did not meet this criterion were missing discussion of changes in risk that potentially impacted the content of the PNMPs.

c. and d. Examples of concerns included:

- Often, IDTs did not address individuals' OT/PT needs by including interventions in ISP action plans, and/or include goals/objectives for direct therapy that OT/PTs recommended or implemented.
- IDTs also did not hold ISPA meetings to review and approve OT/PT assessment recommendations for the initiation of or modification to therapy services and supports.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.	
Summary: Given that over the last two applicable review periods and during this review, newly-admitted individuals reviewed generally had timely communication screenings (Round 10 – 100%, Round 11 – N/A, Round 12 – 100%, and Round 13 - 100%), Indicator a.i will move to the category requiring less oversight. Communication assessments included a number of positive components. However,	Individuals:

work is needed to improve the quality of communication assessments and updates in order to ensure that AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills; and coordination occurs between SLPs and Behavioral Health Services staff. The remaining indicators will continue in active oversight.											
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	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								0/1	
	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.	43% 3/7	0/1	0/1	1/1	1/1	N/A	0/1	1/1	N/A	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	56% 5/9	1/1	0/1	1/1	1/1	1/1	0/1	1/1	0/1	0/1
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	25% 1/4	N/A	1/1	N/A	N/A	N/A	0/1	N/A	0/1	0/1

	Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments: a. through c. The following provides information about problems noted:

- On 12/2/17, the SLP completed Individual #103's communication assessment for the ISP held on 12/14/17. It should have been completed no later than 11/30/17.
- For Individual #77, and Individual #68, the SLP completed screenings. The SLP did not provide clear justification for the decision to not complete full assessments. The State disputed these findings in the draft report. The Monitoring Team reviewed the findings, and changed the score for Individual #61, because the SLP provided information in the screening about past efforts to provide communication supports, described why they were unsuccessful, and confirmed that the individual's status had not changed. However, for Individual #77, and Individual #68, the SLP did not justify why they would not benefit from supports to improve or expand their skills. Their scores remained the same.
- For Individual #67, on 5/26/17, the SLP signed a screening completed for an ISP meeting held on 4/18/17. In its comments on the draft report, the State indicated that the IDT had access to a screening dated 3/31/17. However, as indicated in the draft report, despite a second request for previous assessments, the Center did not provide them. As a result, it remained unclear whether or not a screening was sufficient to address the individual's needs. The scores did not change.

d. and e. As discussed above, for Individual #61, Individual #77, Individual #68, and Individual #67, justification was not found for the lack of an assessment. On a positive note, all five assessments reviewed provided, as applicable:

- The individual's preferences and strengths are used in the development of communication supports and services;
- 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; and
- The effectiveness of current supports, including monitoring findings.

The following describes some of the concerns with the assessments reviewed:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Most assessments did not describe the impact of these issues on the individuals' communication;
- 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: No assessment of EC was provided for Individual #15. In its comments on the draft report, the State disputed this finding, and quoted sections of the assessment that referenced past assessments, not a current assessment. The SLP did not offer any information about how the individual's current EC device was working for him, but rather referred the reader to QIDP and BHS progress notes. The SLP did not include evidence that she observed the individual using the device, or that she

assessed the continued need or the individual's potential for using the EC device. The original finding stands. Information about AAC in different sections of Individual #21's assessment was contradictory (i.e., one section of the assessment indicated a full assessment of AAC was not warranted, because he had not had a change of status);

- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated: For most applicable assessments, clear collaboration between the SLP and BHS staff was not evident. In its comments on the draft report, the State disputed this finding. The Monitoring Team reviewed its scoring of the assessments, and did not change its findings. Collaboration needs to go beyond developing/expanding individuals' Communication Dictionaries. Examples of particularly problematic assessments in this regard included Individual #103, Individual #128, and Individual #21; 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: While some of the assessments included thorough lists of communication strategies, two did not (i.e., Individual #128, and Individual #21).

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: The Center's scores remained similar to the last review. To move toward compliance, SLPs should work with QIDPs to ensure that communication strategies and interventions are integrated into individuals' ISPs. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
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	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	67% 2/3	N/A	N/A	1/1	1/1	0/1	N/A	N/A	N/A	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	40% 2/5	0/1	N/A	1/1	1/1	0/1	N/A	0/1	N/A	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. Most ISPs reviewed included complete functional descriptions of the individual's communication skills, which was good to see.

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: Two individuals had no SAPs, and three individuals had one or two SAPs. All five of these individuals could have benefited from more skill training. Further, many of the SAPs that did exist scored low on being practical, functional, and meaningful. They were, however, written in measurable terminology. In addition, none had reliably collected data. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
1	The individual has skill acquisition plans.	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
2	The SAPs are measurable.	100% 16/16	3/3	3/3	2/2	1/1	3/3	No SAPs	3/3	No SAPs	1/1
3	The individual's SAPs were based on assessment results.	44% 7/16	0/3	2/3	0/2	1/1	1/3	No SAPs	3/3	No SAPs	0/1
4	SAPs are practical, functional, and meaningful.	50% 8/16	1/3	3/3	1/2	1/1	1/3	No SAPs	1/3	No SAPs	0/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/16	0/3	0/3	0/2	0/1	0/3	No SAPs	0/3	No SAPs	0/1

Comments:

1. Individual #61 and Individual #150 did not have any 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 #30, and one SAP each for Individual #103 and Individual #44, for a total of 16 SAPS for this review.

3. There was no evidence of assessments conducted for Individual #44's wash his hands SAP, Individual #38's wash his hands SAP, Individual #30's make pizza crust SAP, Individual #92's ride bike SAP, or Individual #115's clear the table, select an avocado, or identify a Clorox bottle SAPs. Additionally, the FSA indicated Individual #38 could turn on his computer, and that Individual #30 could use his computer.

4. Half of the SAPs were rated as practical and functional (e.g., Individual #92's ride a bicycle SAP). The SAPs that were judged not to be practical or functional were (a) not clearly related to the individual's overall ISP goals (e.g., Individual #115's identify a Clorox bottle SAP), (b) had assessments that indicated the individual already possessed the skill (e.g., Individual #30's use the computer SAP), or (c) appeared to be compliance plans (e.g., Individual #44's wash his hands SAP).

5. There were no IOA data to document that the SAPs were reliable. 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 Center had no information about timeliness of submission of these assessments, though about half included recommendations for skill acquisition plans, a slight improvement from the last reviews. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	56% 5/9	1/1	0/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1

Comments:

11. No data about the timeliness of FSAs, PSIs, or vocational assessments were available.

12. Individual #44, Individual #61, Individual #103, Individual #30, and Individual #115'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, 11 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, three other indicators were added to this category, in restraint management.

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

Goals/Objectives and Review of Progress

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 with data and analysis of the data generally 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.

In psychiatry, without measurable goals that met criteria with outcome 1 (including collection of reliable data on psychiatric indicators), progress could not be determined. Generally, psychiatric rating scales were utilized, but no individual-specific symptom/indicator data were collected or trended.

In behavioral health services, without reliable data, it was impossible to assess progress. Performance on progress notes and graphing decreased, perhaps due to the shortage in the staffing of the behavioral health services department.

Acute Illnesses/Occurrences

For acute issues addressed at the Center, improvements are needed to ensure that PCPs/providers assess individuals according to accepted clinical practice. In addition, the PCPs did not complete the necessary follow-up. Of significant concern, nurses did not always notify PCPs of events that might have required a PCP assessment. When individuals were transferred to the hospital, providers documented quality assessments in the IPNs, as applicable. However, follow-up upon individuals' return from the hospital was often lacking. IDT meetings to discuss hospitalizations and next steps often did not have the necessary attendance and participation of the PCP.

With regard to acute illnesses/occurrences, improvement was needed with regard to nursing staff's assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis until the issue resolved; timely notification of the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification; and development of acute care plans that are consistent with current generally accepted standards.

In psychiatry, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

Data were presented in clinical meetings and follow-up occurred. Another positive was the re-implementation of regularly occurring internal and external peer reviews.

Implementation of Plans

As noted above, for individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs for nursing supports due to lack of inclusion of regular assessments in alignment with nursing guidelines and current standards of care. As a result, data often were not available to show implementation of such assessments. In addition, for the individuals reviewed, evidence was generally not provided to show that IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly. As a result, a number of individuals reviewed were at significant risk of harm.

For a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate. However, more work is needed, because for other individuals, some significant concerns were identified.

Although the PCP indicated agreement or disagreement with non-Facility consultations, and generally wrote IPNs that included the necessary components, these reviews often occurred a month or more after the consultation appointment. Given the importance of consultations in the provision of medical supports, it is essential that these activities occur timely.

On a positive note, for the most part, medical practitioners 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.

Although some improvement was noted with regard to the provision of dental treatment, more work is needed, particularly to ensure that individuals receive needed prophylactic care, tooth brushing instruction, and assessments/provision of dentures. In addition, sometimes due to the length of time since the individual's last complete exam (i.e., full exam needed under general anesthesia/TIVA), it was unclear what treatment he/she needed.

With regard to Quarterly Drug Regimen Reviews (QDRRs), they were generally timely, which was good to see. The Clinical Pharmacist should focus on making recommendations, as needed, to address abnormal lab values, and improving the review for the risk of metabolic syndrome for individuals prescribed new-generation antipsychotic medications.

Since the last review, improvement was seen with regard to the cleanliness, as well as the working condition of adaptive equipment. Substantial work is needed, however, with regard to ensuring the proper fit of individuals' adaptive equipment.

Based on observations, there were still numerous instances (52% of 52 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.

Psychiatry-neurology consultation continued and there were good notes indicating collaboration.

Regarding psychiatry activities, performance decreased from 100% from the last at the last review regarding conduct and content of quarterly reviews, and observation of quarterly clinic. This was likely due, at least in part, to the changes in the psychiatry staffing at Rio Grande SC. Also, no psychiatry clinics were being held and none were held during the onsite week.

Polypharmacy committee continued to operate well, however, during the onsite week, the Monitoring Team learned that the current chair would be leaving and that polypharmacy committee was going to be conducted in a different manner with different staff.

None of the individuals had documentation that at least 80% of direct support professionals (DSPs) working in their residence were trained on their PBSPs.

Positive changes were made in the Center's overall data collection systems for target and replacement behaviors. This was good to see. Rio Grande SC was not yet meeting criteria regarding ensuring reliable data collection and high treatment implementation accuracy.

Restraints

<table>
<tr><td colspan="12">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.</td></tr>
<tr><td colspan="3">Summary: Three indicators regarding holding meetings and presences of a PBSP were in place for this review and previous reviews, too. Therefore, these three indicators (18, 19, 24) will be moved to the category of requiring less oversight. The other indicators, regarding the important review, discussion, and planning that are to occur when individuals have frequent restraints, were not occurring. Thus, these other indicators will remain in active monitoring.</td><td colspan="9">Individuals:</td></tr>
<tr><td>#</td><td>Indicator</td><td>Overall Score</td><td>44</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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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.	100% 1/1	1/1								
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	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?	0% 0/1	0/1								
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/1	0/1								
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).	0% 0/1	0/1								
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.	0% 0/1	0/1								

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

18. Individual #44 was restrained seven times on 6/18/18. His IDT met to review more than three restraints in 30 days on 6/22/18.

19. Individual #44 had more than three restraints in 30 days in January 2018 and in June 2018. ISPAs to address more than three restraints in 30 days occurred on 1/22/18 and 6/22/18.

20. Individual #44's IDT hypothesized that psychiatric/anxiety issues contributed to the occurrence of his dangerous target behaviors that provoked restraint. Additionally, the IDT suggested that the role of his anxiety be discussed in this next psychiatric meeting.

21. Contributing environmental variables were not discussed in Individual #44's ISPA for more than three restraints in 30 days.

22. Individual #44's IDT identified denial of desired items or actions as antecedents to Individual #44's restraints, however, no actions (other than continue following the PBSP) to address this antecedent in the future was suggested (e.g., retrain staff, modify statements of how to deny requests).

23. Variables maintaining Individual #44's dangerous behaviors that provoke restraint were not discussed in his ISPA.

25. Individual #44 did not have a CIP.

28. Individual #44 did not have treatment integrity data.

29. Individual #44's PBSP was not reviewed in his 6/22/18 ISPA.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: All of the individuals in the review groups were seen by psychiatry, therefore, these indicators did not apply to any of them. The Monitor will keep these indicators in active monitoring for review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score									
1	If not receiving psychiatric services, a Reiss was conducted.	N/A									
2	If a change of status occurred, and if not already receiving psychiatric	N/A									

	services, the individual was referred to psychiatry, or a Reiss was conducted.										
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A									

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, all were receiving psychiatric services. As such, the Reiss screen was not applicable to any individuals in the review group.

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 (including collection of reliable data on psychiatric indicators), progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
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% 7/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	1/1
11	Activity and/or revisions to treatment were implemented.	86% 6/7	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	0/1

Comments:
8-9. Two individuals had measurable goals regarding reductions in psychiatric indicators included in the IHCP. There were no measurable goals regarding increases in desirable activities included in the IHCP. In the absence of goals for both reductions and increase, it was not possible to determine progress. Further, without reliable data on psychiatric indicators, progress could not be determined.

10-11. Despite the absence of measurable goals, it was apparent that, in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments, changes in the living environment, and alterations to non-pharmacological interventions) were developed and implemented.

There were two individuals who were noted to be psychiatrically stable, Individual #150 and Individual #92. As such, these individuals had not required alterations to their treatment plan in some time and were not included in the scoring of these two indicators.

One individual, Individual #44, was refusing to take his prescribed psychotropic medications since late June/early July 2018. Previously, he was court-ordered to adhere to the medication regimen. Unfortunately, the court order expired and he began to refuse medication, a situation that resulted in an increased symptom experience and the need for enhanced/1:1 supervision. The facility realized the lapse in the court order during the monitoring visit and submitted an application to the court to renew the court order. Just prior to the submission of this report, the Monitoring Team learned that the court order had been resolved and re-instated in early October 2018.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.

Summary: Both indicators declined from 100% performance at the last review. With upcoming changes to the psychiatry department staff, these indicators should be able to return to that level of performance. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
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.	56% 5/9	1/1	0/1	1/1	0/1	1/1	1/1	1/1	0/1	0/1
24	The psychiatrist participated in the development of the PBSP.	7/9 78%	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:

23. The psychiatric documentation generally referenced the behavioral health target behaviors. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in five examples.

In two examples, regarding Individual #92 and Individual #150, the behavioral health evaluations were out of date.

In two other examples, the behavioral health assessment did not adequately review the effect of the individual's diagnosis with respect to the behavioral challenges. For example, with regard to Individual #103, the psychiatrist reviewed the behavioral health target behaviors. While the functional assessment noted the diagnoses, and some documentation regarding this individual's behavioral challenges and the relationship of these to autism, he also had a diagnosis of bipolar mood disorder and there was no notation if the target behaviors were increased or impacted by mood cycles.

24. There was documentation of psychiatric participation for the individuals who had a current PBSP (i.e., two did not have a current PBSP). The review of the PBSP was documented in the psychiatric quarterly and the psychiatrist signed the PBSP. This was good to see.

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: Neurology consultation continued and there were good notes indicating collaboration. One individual, however, was being prescribed an AED, but without clear coordination between psychiatry and neurology. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	75% 3/4	1/1			0/1	1/1	1/1			
26	Frequency was at least annual.	100% 4/4	1/1			1/1	1/1	1/1			
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	75% 3/4	1/1			0/1	1/1	1/1			

Comments:
25 and 27. These indicators applied to four of the individuals in the review group. Although the neurology clinical encounters occurred off campus, there was documentation by the psychiatrist of a review of the clinical encounter. In a positive example, regarding Individual #61, there was documentation of a neurology consult and a verbal consultation between neurology and psychiatry documented by psychiatry.

In the case of Individual #103, it was not clear if the seizure medication, specifically Depakote, was considered a dual purpose medication or not. The psychiatrist was managing this medication and there was a note from neurology at the last clinical encounter in February 2018 to continue the current AED. As this was the only AED this individual was prescribed, it appeared that Depakote was the medication the neurologist was referring to.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Performance decreased from 100% on all three indicators at the last review. This was likely due, at least in part, to the changes in the psychiatry staffing at Rio Grande SC. Also, no psychiatry clinics were being held and none were held during the onsite week. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
33	Quarterly reviews were completed quarterly.	67% 6/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	0/1	1/1
34	Quarterly reviews contained required content.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	None held									

Comments:
33. There were delays in the completion of quarterly reviews for three individuals, Individual #61, Individual #127, and Individual #150.

34. The Monitoring Team looks for nine components of the quarterly review. Two of the examples included all the necessary components. The evaluations were missing from one to three of the required elements.

35. During the monitoring visit, there were no psychiatric clinics. The previous provider stopped providing services in July 2018. A nurse practitioner started work at the facility the week of the visit, but was awaiting a collaborative practice agreement to begin providing services

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: For two-thirds of the individuals, there were delays in the completion of the side effect assessments (two) and/or delays in the prescriber's review (four). This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	33% 3/9	0/1	0/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1
Comments: 36. There were delays in both the completion of the assessment and the prescriber review of the assessments.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary:			Individuals:								
#	Indicator	Overall Score									
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:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators stay in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
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.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A									
Comments: 42. Individual #92 and Individual #150 were prescribed psychotropic medication, but their behavioral treatment programs were outdated.											

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: Polypharmacy committee continued to operate well, however, during the onsite week, the Monitoring Team learned that the current chair would be leaving and that polypharmacy committee was going to be conducted in a different manner with different staff. Thus, this indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
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 changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 3/3				1/1		1/1			1/1
Comments: 46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for the three individuals meeting polypharmacy criteria.											

The polypharmacy committee meeting was observed during the visit. The polypharmacy committee meeting was a case review with questions for justification submitted to the treating psychiatrist for consideration and response. Overall, this was a comprehensive review of the medication regimens meeting criteria for polypharmacy.

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 (indicator 5), 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.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
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.	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, worsening, and/or not stable, corrective actions were identified/suggested.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments:
6. At the time of the document review, Individual #38 and Individual #44 had current graphed Center data reflecting progress on PBSP target behaviors. Neither Individual #38 nor Individual #44's PBSP data indicated they were progressing as expected. The remaining individuals were scored as zero because the data were not demonstrated to be reliable (indicator #5).

8-9. Individual #38 and Individual #44 were not making expected progress, and their progress notes indicated that staff were retrained.

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

Summary: Same as at the last review, more training needs to occur for all staff members regarding individuals' PBSPs, thus, indicator 16 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
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, this indicator was 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 (DSPs) working in their residence were trained on their PBSPs. 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: Performance on progress notes and graphing decreased, perhaps due to the shortage in the staffing of the behavioral health services department. Data were presented in clinical meetings and follow-up occurred. With sustained high performance of this activity, indicators 21 and 22 might be moved to the category of requiring less oversight after the next review. Another positive was the re-implementation of regularly occurring internal and external peer reviews. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
19	The individual's progress note comments on the progress of the individual.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
20	The graphs are useful for making data based treatment decisions.	22% 2/9	0/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 1/1									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.	100% 1/1									1/1
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.	100%									

Comments:
19. Individual #38 and Individual #44 had timely progress notes that described individual progress. Individual #127, Individual #30, and Individual #115 did not have progress notes. Individual #150, Individual #61, Individual #103, and Individual #92 did not have current progress notes at the time of the document review. Ensuring that all individuals have current progress notes should be a

priority for Rio Grande SC.

20. Individual #38 and Individual #44 had graphs of current data that encouraged data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends.

21. In order to score this indicator, the Monitoring Team observed Individual #44's ISPA meeting. Recent data were available and used to make data based clinical decisions.

22. There was documentation that suggestions made in Individual #44's peer review were implemented.

23. There was documentation that Rio Grande SC conducted weekly internal and monthly external peer review meetings. This represents another improvement from the last review when regular peer review was not being implemented.

Outcome 8 – Data are collected correctly and reliably.

Summary: The data collection systems for recording occurrences of target and replacement behaviors improved since the last review. Further, there were established measures of data and treatment integrity in place. Thus, indicators 26, 27, and 28 improved to 100% performance compared with 0% performance at the last review. The data, however, were not yet being assessed regularly enough or targets for integrity yet being met. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
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. The data collection system for measuring undesired (target) behaviors consisted of staff recording the occurrence of target behaviors in two-hour intervals for higher frequency behaviors, and frequency per shift for low frequency behaviors. This system represents an improvement from the data collection system described in the last review.

The Monitoring Team observed Individual #44 engage in a target behavior during the onsite review. The next morning, the Monitoring Team reviewed Individual #44's data sheet, and was encouraged to see that the target behavior was recorded.

27. The data collection system for measuring replacement behaviors utilized an interval scoring method and represented an adequate tool for measuring replacement behaviors.

28. There were established measures of IOA, treatment integrity., and 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 treatment integrity, IOA, or data collection timeliness measures of their PBSP data in the last six months.

It is critical that Rio Grande SC ensure that PBSP data are reliable, and that PBSPs are implemented with integrity. In order to achieve this the facility needs to consistently assess (and retrain as necessary) IOA, data collection timeliness, and treatment integrity (indicators 5, 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 clinically-relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	22% 2/18	0/2	2/2	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(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	0%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

	necessary action.	0/18									

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #103 – cardiac disease, and aspiration; Individual #61 – osteoporosis, and seizures; Individual #108 – cardiac disease, and diabetes; Individual #128 – other: Down syndrome, and other: hypothyroidism; Individual #21 – other: Down syndrome, and constipation/bowel obstruction; Individual #77 – diabetes, and cardiac disease; Individual #15 – other: hypertension, and constipation/bowel obstruction; Individual #68 – diabetes, and other: hypothyroidism; and Individual #67 – infections, and constipation/bowel obstruction).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #61 – osteoporosis, and seizures; Individual #68 – diabetes; and Individual #67 – 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 provision 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, these indicators will continue in active oversight until improvement is noted, and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. For the most part, medical practitioners 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. If the Center sustains this performance, after the next review, Indicator b might move to the category of less oversight.

Individuals:

#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	100% 3/3	N/A	N/A	1/1	N/A	N/A	N/A	1/1	N/A	1/1
	iii. Breast cancer screening	50% 1/2	N/A	1/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A

	iv. Vision screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	57% 4/7	1/1	1/1	0/1	N/A	1/1	1/1	0/1	0/1	N/A
	vii. Cervical cancer screening	0% 0/2	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	89% 8/9	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1

Comments: a. The following problems were noted:

- Reportedly, Individual #103 had TDap administered in the ED, but a date was not provided.
- In January 2016, Individual #61 had a well-woman exam. Given her history and medication regimen, she was to return for follow-up in a year. As of August 2018, no follow-up was documented.
- For Individual #108:
  - Information regarding mammograms only stated: "multiple unsuccessful attempts." The AMA stated that a bilateral breast ultrasound would be completed, but documentation was not submitted to show this occurred.
  - The eye exam, dated 9/25/17, recommended follow-up in six months. No such follow-up was found in the documents the Center submitted.
  - Her last pap exam was in 2009. She had a history of uterine fibroids.
  - She had no documented DEXA scan.
- According to Individual #15's AMA, his age, previous hip fracture, medications, and Vitamin D deficiency put him at high risk for osteoporosis. The PCP documented that attempts were unsuccessful in 2011 and pre-treatment sedation and "sleep deprivation" were necessary to obtain a DEXA. Based on documentation submitted, the DEXA scan was never completed.
- For Individual #68:
  - The Center submitted documentation indicating a DEXA scan was not applicable for him. However, he had a history of long-term psychotropic medication use, a very low Vitamin D level, and a long-bone comminuted fracture from a same-level fall. Given his risk factors, a DEXA scan should have been considered.
  - On 5/8/18, testing showed he had no Hepatitis B antibodies, which should have resulted in vaccination, but did not.
  - There was no documentation of TDap.

b. It was positive that for most individuals reviewed, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, the prescribing medical practitioners addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. The exception was for Individual #128. He was rated at low risk for metabolic syndrome, but documentation indicated that he had a strong family history and increased risk due to psychotropic medication. Moreover, this individual had Down syndrome, which is associated with an increased risk of endocrine abnormalities, such as thyroid dysfunction and

diabetes.

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: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
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. None of the individuals reviewed had a DNR Order.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: For acute issues addressed at the Center, improvements are needed to ensure that PCPs/providers assess individuals according to accepted clinical practice. In addition, the PCP did not complete the necessary follow-up. Of significant concern, nurses did not always notify PCPs of events that might have required a PCP assessment. When individuals were transferred to the hospital, providers documented quality assessments in the IPNs, as applicable. However, follow-up upon individuals' return from the hospital was often lacking. IDT meetings to discuss hospitalizations and next steps often did not have the necessary attendance and participation of the PCP. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	50% 2/4	1/2	N/A	N/A	N/A	1/1	N/R	N/A	0/1	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	0% 0/4	0/2				0/1			0/1	
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP	50% 4/8	N/A	1/1	1/1	1/1	N/A	0/2	1/2	N/A	0/1

	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.										
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 3/3		1/1	N/A	N/A		1/1	1/1	N/A	N/A
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	88% 7/8		1/1	1/1	1/1		1/2	2/2	N/A	1/1
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, this indicator 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.	38% 3/8		N/A	0/2	N/A		0/2	2/2	1/1	0/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	20% 2/10		0/1	0/2	0/1		0/2	2/2	0/1	0/1

Comments: a. For three of the nine individuals, the Monitoring Team reviewed four acute illnesses addressed at the Center, including: Individual #103 (right eye redness on 1/14/18, and corneal ulcer on 2/9/18), Individual #21 (blepharitis on 4/19/18), and Individual #68 (humeral fracture on 5/15/18).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #103 (corneal ulcer on 2/9/18), and Individual #21 (blepharitis on 4/19/18).

In at least two instances, nurses did not notify PCPs of events that might have required a PCP assessment. Although the Monitoring Team did not score these events, this finding is of significant concern. For example:

- On 7/10/18, Individual #21 was involved in a motor vehicle accident. Staff did not notify the PCP.
- On 2/10/18, Individual #77 fell off of the commode and hit his head on the floor. A 2-centimeter (cm) laceration was noted on the top of his head. Nursing staff reported his neurological status as normal, and placed him on mild head injury precautions. Nursing staff did not document the exact nature of the laceration, and they did not document physician notification. Beginning on 2/11/18, the individual began refusing medications and meals. On 2/15/18, he was sent to the ED for evaluation of hypersomnia and dehydration.

b. The PCP did not conduct follow-up assessments and documentation at a frequency consistent with the individuals' status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- On 1/14/18, nursing staff documented that Individual #103 had right eye redness. It was documented that the PCP cleaned the eye with normal saline and stated no further treatment was necessary.

  On 2/9/18, the PCP evaluated Individual #103 due to drainage from the right eye. Antibiotic drops were instilled and an eye patch was placed. Within a few hours, the ophthalmologist evaluated the individual, and diagnosed him with an infected corneal abrasion that needed aggressive management. On 2/10/18, follow-up occurred and was significant for the development of a corneal ulcer. The individual had daily follow-up with ophthalmology until his condition improved.

  On 4/6/18, the PCP documented that the right eye was red again. The PCP noted that the individual was scheduled for follow-up on 4/13/18. Given the history of a corneal ulcer, an emergent consult might have been warranted. On 4/11/18, the ophthalmologist evaluated the individual who noted the presence of a corneal ulcer with a scar.
- On 4/19/18, Individual #21 was diagnosed with left eye blepharitis and started on antibiotic drops for a total of nine days. The plan was to follow up in four to five days if needed. There was no follow-up documented.
- On 5/15/18, at around 5:45p.m., Individual #68 fell and sustained an injury to the left arm. The PCP was notified, and prescribed Tylenol. The PCP requested that an x-ray be done, if the pain persisted. At approximately 10:40 p.m., the x-ray was completed. Shortly after midnight, the PCP was notified that the individual had a humeral fracture. Orders were given to refer him to the clinic in the morning.

  Although the individual had a significant fracture of a long bone, the PCP did not conduct an immediate evaluation or make a referral to the ED. On 5/16/18, at around 10:50 a.m., the individual was seen in clinic. The plan was to immobilize the arm, and on 5/18/18, have a scheduled orthopedic evaluation. The PCP did not complete a follow-up assessment. On 5/18/18, an orthopedic evaluation was completed. The diagnosis was 4-part fracture left humerus, displaced, and the recommendation was to have a total shoulder arthroplasty (i.e., shoulder replacement).

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 10 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #61 (human bite on 5/29/18), Individual #108 (cardiac arrest on 5/3/18, and pneumonia and hypoxia on 5/8/18), Individual #128 (head trauma and hematoma on 8/22/18), Individual #77 (syncope on 4/3/18, and GI bleeding and shock on 4/27/18), Individual #15 (influenza and pneumonia on 1/6/18, and volvulus on 6/14/18), Individual #68 [open reduction and internal fixation (ORIF) for humeral fracture on 5/31/18], and Individual #67 (gallstone pancreatitis on 1/27/18).

c. through e., g., and h. The following provide examples of the findings for these acute events:

- It was positive to see that the following individual displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #15 (volvulus on 6/14/18).
- On 5/29/18, another individual bit Individual #61's left third finger. The PCP assessed the individual and referred her to the ED for further evaluation and treatment. Per the ED assessment, the left third fingernail was avulsed and superficial bite wounds were present. Labs and x-rays were done. On 6/1/18, the PCP saw her. The plan was to continue local wound care

and antibiotics for seven days.

Based on the records of both individuals and the type of injury, it was determined that the transmission of infectious diseases was low risk. However, there was no further follow-up. ED records documented that serology for Hepatitis B, C, and human immunodeficiency virus (HIV) were drawn in the ED. The Center submitted no documentation of wound follow-up or the results of studies done in the ED.

- On 5/3/18, Individual #108 was scheduled to have dental evaluation and treatment under general anesthesia. She experienced cardiac arrest, was resuscitated, and admitted to the hospital. On 5/7/18, at around 1:30 p.m., she returned to the Center. Even though her discharge diagnoses were status post (S/P) cardiac arrest and cardiomyopathy, the PCP did not evaluate her upon her return to the Center.

  On 5/8/18, at around 1 a.m., the individual was transferred to the ED for respiratory distress. On 5/9/18, the PCP wrote an after-hours note. On 5/11/18, Individual #108 returned to the Center with the discharge diagnoses of pneumonia, cardiomyopathy with ejection fraction (EF) 15%, right arm deep vein thrombosis (DVT), and oxygen dependence. On 5/11/18, the PCP evaluated her. Based on the documents provided, until 5/29/18, the PCP did not conduct and/or document any further medical assessments.

  On 5/7/18, and 5/14/18, the IDT held ISPA meetings, but the PCP did not attend either post-hospitalization meeting.
- On 3/23/18, staff reported that another individual had possibly assaulted Individual #128. During the assault, the individual sustained head trauma and possible loss of consciousness (LOC). He was seen in the ED and discharged with the diagnosis of facial trauma and closed head injury. The following day, the PCP wrote an after-hours transfer note.

  On 3/23/18, the PCP saw him, and documented that the individual had an ataxic gait, head trauma, and a scalp hematoma, and further evaluation would be done. Per the PCP: "Client is medically stable at this time and we will likely follow-up with him in the next couple of days to ensure that his state is improving." On 3/26/18, the PCP documented a review of the hospital records, but did not complete a physical assessment. The plan was to follow up as needed.

  On 3/28/18, the PCP conducted an assessment noting that the scalp hematoma had improved and ataxic gait resolved. The plan was to discontinue one-to-one supervision. The PCP indicated that the individual was medically stable and did not require further follow-up at that time.
- Based on documentation submitted, on 4/3/18, at around 4:00 a.m., Individual #77 collapsed while staff was attempting to get him up. He transferred emergently to the ED and was admitted with syncope and respiratory failure. He required intubation and mechanical ventilation, as well as placement of a permanent pacemaker.

  On 4/17/18, he returned to the Center, and on 4/18/18, the PCP saw him. The plan was to have psychiatry adjust medications and follow up with cardiology. On 4/19/18, the PCP conducted no follow-up. On 4/20/18, the PCP documented that psychotropic medications were decreased. Cardiology follow-up was still needed. The next PCP assessment was on 4/27/18.

  On 4/20/18, the IDT held an ISPA meeting. However, despite the individual's long hospitalization with multiple medical

problems, the PCP did not attend the meeting.

On the night of 4/26/18, the records documented low blood pressure readings. However, at that time, the only intervention was "monitoring." On 4/27/18, the PCP noted: "I was notified that client had not slept well, was noted to be pale and possibly dehydrated. He was monitored during the night and on-call PCP wanted blood work and assessment by PCP or evaluation by ER." The PCP sent the individual to the ED due to the hypotension, and a critically low hemoglobin (Hb) of 4.9. He was admitted with hypotension due to hemorrhagic shock secondary to a bleeding gastric ulcer. On 5/11/18, he returned to the Center.

On 5/11/18, the PCP evaluated Individual #77. The discharge diagnoses were GI bleed with shock and Addison's disease. On 5/12/18, the PCP assessed the individual again. There was no documentation of additional follow-up for this individual who was hospitalized due to a critical illness. On 5/18/18, Individual #77 was sent to ED again with hypotension and GI bleeding.

On 5/17/18, the IDT held an ISPA meeting. However, despite the individual's medical problems, the PCP again did not attend the meeting.

- On 1/6/18, at around 7:00 a.m., Individual #15 had a temperature of 101.3. Nursing staff notified the PCP who gave orders to administer Tylenol. At around 4:25 p.m., nursing staff documented the presence of a wet productive cough and rhonchi. The individual's temperature was 102. Nursing staff notified the PCP, and documented that at approximately 8:00 p.m., the PCP was at the individual's bedside and requested transfer to the hospital. However, the PCP did not complete a note documenting an assessment.

  On 1/6/18, the individual was admitted to the hospital, and on 1/16/18, he was discharged. The PCP saw him upon his return and documented the discharge diagnoses as influenza A, pneumonia, abdominal distention, and dysphagia. On 1/17/18, the PCP saw him again.
- On 5/31/18, Individual #68 had an ORIF done on his left shoulder and returned to Center. There was no PCP evaluation documented. Based on the documentation submitted, the last PCP evaluation occurred on 5/27/18. For this individual, it appeared the Center might have omitted a significant number of IPN entries.
- On 1/25/18, Individual #67 had emesis and nursing staff placed him on the vomiting protocol, but did not notify the physician. On 1/26/18, the individual vomited again. Nursing staff contacted the on-call MD who requested transfer to the ED for evaluation. No after-hour PCP transfer note was found. On 1/27/18, the individual was evaluated and treated for gallstone pancreatitis in the Emergency Department. He was discharged back to the Center.

  On 1/28/18, the PCP conducted a follow-up and documented that follow-up would occur as needed. On 2/1/18, the PCP documented a review of the hospital notes and made an IPN entry noting that the individual would be referred to general surgery for a cholecystectomy. On 2/2/18, the IDT held an ISPA meeting, but the PCP was not present to answer questions raised about next steps for medical care.

  On 3/26/18, the PCP documented that the surgeon recommended a cholecystectomy, based on a consult, dated 2/27/18, and the matter would be referred to the IDT. In the records reviewed, there was no documentation that a cholecystectomy was

completed.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: Although the PCP indicated agreement or disagreement with non-Facility consultations, and generally wrote IPNs that included the necessary components, these reviews often occurred a month or more after the consultation appointment. Given the importance of consultations in the provision of medical supports, it is essential that these activities occur timely. As a result, all of the remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
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% 17/17	2/2	2/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	53% 9/17	1/2	1/2	2/2	1/2	1/2	1/1	0/2	2/2	0/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	94% 16/17	2/2	2/2	1/2	2/2	2/2	1/1	2/2	2/2	2/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	60% 3/5	0/1	1/1	N/A	N/A	N/A	N/A	N/A	1/1	1/2

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 17 consultations. The consultations reviewed included those for Individual #103 for gastroenterology (GI) on 4/16/18, and ophthalmology on 6/27/18; Individual #61 for neurology on 6/28/18, and endocrinology on 4/19/18; Individual #108 for cardiology on 6/12/18, and eye on 6/11/18; Individual #128 for eye on 2/28/18, and pulmonary on 1/24/18; Individual #21 for eye on 5/21/18, and hematology/oncology on 1/19/18; Individual #77 for neurology on 1/4/18; Individual #15 for eye on 4/30/18, and hematology/oncology on 4/16/18; Individual #68 for eye on 5/16/18, and orthopedics on 5/18/18; and Individual #67 for general surgery on 2/27/18, and GI on 5/1/18.

a. For all of the consultation reports reviewed, PCP indicated agreement or disagreement with the recommendations, and provided rationales for disagreements.

b. The reviews that PCP did not complete timely were for: Individual #103 for GI on 4/16/18; Individual #61 for neurology on 6/28/18; Individual #128 for eye on 2/28/18; Individual #21 for eye on 5/21/18; Individual #15 for eye on 4/30/18, and hematology/oncology on 4/16/18; and Individual #67 for general surgery on 2/27/18, and GI on 5/1/18. Often, the reviews occurred a month or more after

the consultation appointment.

c. Most of the PCP IPNs related to the consultations reviewed included all of the components State Office policy requires. The exception was for Individual #108 for eye on 6/11/18, for which the PCP did not explain the significance of the results in language IDT members could easily understand.

e. The following problems were noted:

- For Individual #103's GI consultation on 4/16/18, the PCP did not make a referral to the IDT, but given the recommendations, a referral to the IDT was needed. The gastroenterology consultant concluded that the individual had dysphagia, unspecified, likely due to his seizure disorder. The modified barium swallow study (MBSS) showed a severe choking hazard and high aspiration risk. The individual had GERD with esophagitis. The consultant's recommendations were to modify his diet per the MBSS results, percutaneous endoscopic gastrostomy tube (PEG-tube) placement if the individual was unable to his maintain weight, as well as anti-reflux measures.
- For Individual #67, the PCP did not make a referral to the IDT regarding the scheduled colonoscopy that required a bowel preparation.

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

Summary: For a number of individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate. However, more work is needed, because for other individuals, some significant concerns were identified. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	67% 12/18	0/2	2/2	1/2	2/2	2/2	2/2	0/2	1/2	2/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #103 – cardiac disease, and aspiration; Individual #61 – osteoporosis, and seizures; Individual #108 – cardiac disease, and diabetes; Individual #128 – other: Down syndrome, and other: hypothyroidism; Individual #21 – other: Down syndrome, and constipation/bowel obstruction; Individual #77 – diabetes, and cardiac disease; Individual #15 – other: hypertension, and constipation/bowel obstruction; Individual #68 – diabetes, and other: hypothyroidism; and Individual #67 – infections, and constipation/bowel obstruction).

a. It was positive that for the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #61 – osteoporosis, and seizures; Individual #108 – diabetes; Individual #128 – other: Down syndrome, and other: hypothyroidism; Individual #21 – other: Down syndrome, and constipation/bowel obstruction; Individual #77 – diabetes, and

cardiac disease; Individual #68 – other: hypothyroidism; and Individual #67 – infections, and constipation/bowel obstruction. The following provides examples of concerns noted:

- On 2/7/18, Individual #103's PCP documented that the individual was being assessed for reports of tachycardia and increased falls. Orthostatic vital signs were taken and the individual was orthostatic based on heart rate. The plan was to repeat an electrocardiogram (EKG) and complete a 24-hour Holter monitor. Given the documented orthostatic hypotension, it was unclear why the PCP wrote: "Client is medically stable at this time and does not require follow-up or close monitoring just yet." Moreover, according to the AMA, the individual had elevated blood pressures without a diagnosis of hypertension and was started on propranolol.

  In March 2018, the interval medical review documented that on 3/5/18, a cardiology evaluation was done. The Holter monitor showed significant tachycardia and frequent premature ventricular complexes (PVCs) combined with ventricular tachycardia. The recommendation was to start metoprolol and obtain an echocardiogram (echo).

  On 4/10/18, the PCP made an IPN entry related to the echo results. The echo was essentially normal. The PCP noted no cardiac etiology evidence for tachycardia, and indicated a referral to the IDT was not needed.

  It should be noted that there was no echocardiographic etiology for the tachycardia. However, as stated above, the cardiologist clearly stated in the consult, dated 3/5/18, that the Holter monitor showed significant tachycardia and frequent PVCs consistent with ventricular tachycardia. The recommendation was to start metoprolol and obtain the Echo. Moreover, the cardiologist stated: "he is on multiple other medications which may effect [sic] his metoprolol." The assessment was tachypnea and hypothyroidism. The individual was referred due to tachycardia, palpitations, and chest pain. The PCP should have sought further clarification of this consult. Of note, the Registered Nurse Case Manager (RNCM) who attended the appointment documented in the IPNs, dated 3/13/18, a response to the psychiatrist: "He was made aware that [the cardiologist] did not express any concerns in regards to clients [sic] current psychotropic therapy." The cardiologist appeared to have concerns about medications, but the comments were not clear and the PCP should have clarified them.

  The ISPA, dated 4/10/18, did not discuss cardiac risk. The IDT should have re-rated this individual and reviewed and revised the IHCP to ensure appropriate supports. Furthermore, many of these problems were potentially medication-induced, such as the tachycardia, QTc changes, and hypothyroidism. The IDT should have reviewed the medications prescribed in an effort to decrease the many medication side effects.
- In December 2017, Individual #103 was hospitalized with sepsis, pneumonia, respiratory failure, and lithium toxicity. The ISPA, dated 2/15/18, indicated that the IDT kept the risk rating for aspiration/respiratory compromise at medium.

  On 4/16/18, the GI consultant, concluded that the individual had dysphagia, unspecified, likely due to his seizure disorder. The MBSS showed a severe choking hazard and high aspiration risk. The individual had GERD with esophagitis. The consultant's recommendations were to modify his diet per the MBSS results, percutaneous endoscopic gastrostomy tube (PEG-tube) placement if the individual was unable to his maintain weight, as well as anti-reflux measures.

  On 4/17/18, the IDT held an ISPA meeting, and documented discussion related to dysphagia and his psychiatric medications. A

plan was implemented to change his medications with both psychiatry and seizure indications. The PCP was not present for this discussion.

On 5/21/18, the psychiatrist made an IPN entry noting there was no need to make any medication changes. On 6/15/18, the GI specialist again noted dysphagia with a severe choking hazard and high risk for aspiration.

- Individual #108's AMA, dated 10/10/17, indicated she had a strong family history of coronary artery disease (CAD). She was diagnosed with hypertension, dyslipidemia, abnormal EKG, and a low ejection fraction.

  A consultation, dated 11/16/11, indicated "possible CAD." A 2011 echo showed an ejection fraction of 40 to 50%, a borderline dilated left ventricle, and a dilated aortic root and ascending aorta. The cardiology consult, dated on 2/6/17, reportedly stated the individual was stable. The PCP's documentation provided no discussion of the possible CAD diagnosis or follow-up of the other conditions. It could not be determined what, if anything, had been done to address the possible CAD, low ejection fraction, and other cardiac abnormalities. The significance of the dilated aortic root was not clear.

  On 5/1/18, the PCP completed an interval medical review, and noted "Exam done and cleared for Dental UGA." It was not clear what criteria the PCP used to "clear" this individual with multiple co-morbidities. She experienced a cardiac arrest during general anesthesia and required cardiopulmonary resuscitation.

  The PCP appeared to defer management to cardiology, but the cardiologist did not appear to adequately evaluate many issues. Overall, the cardiologist frequently appeared to just recommend return of individuals in six months to a year.
- According to Individual #15's AMA, his hypertension was uncontrolled due to salt intake. He had hyponatremia secondary to his psychotropic medications. The hyponatremia was treated with sodium chloride tablets and table salt. This in-turn worsened his hypertension. His cardiac workup, as the cardiologist recommended, had not been completed. The recommendation for a Lexiscan and echocardiogram remained outstanding.

  The documentation did not include a plan to address the treatment with sodium. It was not clear if other psychotropic agents not associated with hyponatremia had been considered. In addition, discussion of hypertension did not include the necessary interventions to determine target organ damage.
- Per Individual #15's AMA, he developed a pseudo-obstruction that required decompression by colonoscopy in 2016, and 2017. Based on the medication list, he was treated with multiple medications for constipation. The AMA did not include any discussion of a bowel management plan, such as medications, fiber, fluids, etc.
- According to Individual #68's AMA, he met the criteria for metabolic syndrome. Moreover, the A1c of 6.2 indicated he met the criteria for prediabetes. Treatment included initiation of an 1800-calorie diet to promote weight loss and maintain blood glucose level. There was no indication that the PCP considered treatment with Metformin, as the American Diabetes Association recommends.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.	
Summary: Most IHCPs reviewed did not include any action steps for PCPs to address individuals' medical needs, but they should have. This indicator will remain in	Individuals:

active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.											
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. As noted above, individuals' IHCPs generally did not include any action steps to address individuals' medical needs. However, for the one IHCP that did include PCP action steps, the PCP implemented them.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: The Clinical Pharmacist should focus on making recommendations, as needed, to address abnormal lab values, and improving the review for the risk of metabolic syndrome for individuals prescribed new-generation antipsychotic medications. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67

a.	QDRRs are completed quarterly by the pharmacist.	88% 15/17	2/2	1/2	2/2	2/2	2/2	1/2	2/2	1/1	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;	71% 12/17	2/2	2/2	2/2	2/2	2/2	0/2	0/2	0/1	2/2
	ii. Benzodiazepine use;	94% 16/17	2/2	2/2	2/2	2/2	2/2	1/2	2/2	1/1	2/2
	iii. Medication polypharmacy;	94% 16/17	2/2	2/2	2/2	2/2	2/2	1/2	2/2	1/1	2/2
	iv. New generation antipsychotic use; and	46% 6/13	2/2	2/2	N/A	0/2	N/A	1/2	0/2	1/1	0/2
	v. Anticholinergic burden.	94% 16/17	2/2	2/2	2/2	2/2	2/2	1/2	2/2	1/1	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, these indicators 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% 7/7	1/1	1/1	2/2	2/2	1/1	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: a. and b. The Center only submitted one QDRR for Individual #77.

b. The following provide examples of concerns noted:

- At times, the Clinical Pharmacist commented on abnormal lab values, but did not make recommendations.
- For Individual #128, the CP stated the individual was not at risk for metabolic syndrome. While he did not meet any of the criteria, he was at increased risk due to the use of a second-generation antipsychotic. Moreover, he had Down syndrome, which increases the risk for diabetes mellitus.
- Individual #15 was prescribed Zyprexa. The Clinical Pharmacist stated the individual was not at risk for metabolic syndrome.

However, he was treated with atorvastatin for hyperlipidemia, and had an A1c of 5.6, which is the upper limit of normal.

- For Individual #68, the Clinical Pharmacist noted that metabolic syndrome was present. The A1c of 6.2 was documented in the QDRR, but the Clinical Pharmacist did not note that this met criteria for the diagnosis of prediabetes. Therefore, the Clinical Pharmacist made no recommendation to consider pharmacologic intervention.
- For Individual #67, the Clinical Pharmacist noted that the individual was not at risk for metabolic syndrome. The use of Zypexa increases the risk for metabolic syndrome. Moreover, the individual's A1c was 5.5, which is high normal.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them.

e. As noted with regard to Outcome #1, the Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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: 103	61	108	128	21	77	15	68	67
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1		0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1		0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1		0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1		0/1

Comments: a. and b. Individual #77 was edentulous, and Individual #68 was at low risk for dental. The Monitoring Team reviewed seven individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

The Monitoring Team will be working with State Office on this issue so that State Office can provide more guidance to the Centers. A

good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day instead of once a day (i.e., specific data is needed to identify the individual's baseline and support the IDT's decision for a reasonable goal/objective), should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

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 generally 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: N/A			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: Individual #77 was edentulous.

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: Although some improvement was noted with regard to the provision of dental treatment, more work is needed, particularly to ensure that individuals receive needed prophylactic care, and tooth brushing instruction. In addition, sometimes due to the length of time since the individual's last complete exam (i.e., full exam needed under general anesthesia/TIVA), it was unclear what treatment he/she needed. The remaining indicators will continue under active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual has teeth, individual has prophylactic care at least	63%	1/1	0/1	0/1	1/1	1/1	N/A	0/1	1/1	1/1

	twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	5/8									
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	75% 6/8	1/1	1/1	1/1	1/1	1/1		0/1	0/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	100% 6/6	1/1	1/1	1/1	1/1	1/1		N/A	N/A	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	1/1	N/A	N/A	N/A	N/A		N/A	N/A	1/1
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A
Comments: a. through f. Individual #77 was edentulous. Although some improvement was noted with regard to the provision of dental treatment, more work is needed, particularly to ensure that individuals receive needed prophylactic care, and tooth brushing instruction. In addition, sometimes due to the length of time since the individual's last complete exam (i.e., full exam needed under general anesthesia/TIVA), it was unclear what treatment he/she needed (e.g., Individual #61, and Individual #15). As a result, it was difficult to determine if individuals had had, for example, all of the restorations they needed.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
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 the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed experienced dental emergencies.											

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	103	61	108	128	21	77	15	68	67

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 received 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 continue in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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, or did not provide an explanation when dentures were not recommended.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.	
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the	Individuals:

nursing guidelines for notification. Acute care plans (ACPs) needed significant improvement. These indicators will remain in active oversight.											
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	63% 5/8	1/1	0/1	0/1	1/1	N/A	0/1	1/1	1/1	1/1
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	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.	20% 1/5	0/1	0/1	N/A	0/1	N/A	N/A	1/1	N/A	0/1
e.	The individual has an acute care plan that meets his/her needs.	22% 2/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1
f.	The individual's acute care plan is implemented.	22% 2/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

Comments: The individuals reviewed experienced a number of acute illnesses. For each individual, the Monitoring Team reviewed one acute illness and/or acute occurrence, including for (with date of initiation of the ACP): Individual #103 – severe conjunctivitis with abrasion on 2/9/18; Individual #61 – human bite on 5/30/18, Individual #108 for bilateral conjunctivitis on 1/8/18, Individual #128 for moderate head injury on 3/23/18, Individual #21 for UTI on 7/11/18, Individual #77 for skin breakdown to coccyx area and right buttock on 7/19/18, Individual #15 for influenza/pneumonia on 1/16/18, Individual #68 for pain secondary to humerus head fracture on 5/17/18, and Individual #67 for acute vomiting on 1/27/18.

a. The acute illnesses/occurrences for which nursing assessments (physical assessments) were performed were for: Individual #15 for influenza/pneumonia on 1/16/18, and Individual #67 for acute vomiting on 1/27/18.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the SSLC nursing guideline entitled: "When contacting the PCP" were: Individual #103 – severe conjunctivitis with abrasion initiated on 2/9/18; Individual #128 for moderate head injury on 3/23/18, Individual #15 for influenza/pneumonia on 1/16/18, Individual #68 for pain secondary to humerus head fracture on 5/17/18, and Individual #67 for acute vomiting on 1/27/18.

Although this initially appears to be a somewhat positive finding, it should be tempered with other findings the Monitoring Team made as a result of this review. As noted in Outcome #6 for medical: "In at least two instances, nurses did not notify PCPs of events that might

have required a PCP assessment. For example:

- On 7/10/18, Individual #21 was involved in a motor vehicle accident. Staff did not notify the PCP.
- On 2/10/18, Individual #77 fell off of the commode and hit his head on the floor. A 2-centimeter laceration was noted on the top of his head. Nursing staff reported his neurological status as normal, and placed him on mild head injury precautions. Nursing staff did not document the exact nature of the laceration, and they did not document physician notification. Beginning on 2/11/18, the individual began refusing medications and meals. On 2/15/18, he was sent to the ED for evaluation of hypersomnia and dehydration.

e. and f. For each of the acute issues reviewed, nursing staff developed an acute care plan. Overall findings included:

- On a positive note, all of the acute care plans included instructions regarding follow-up nursing assessments that were consistent with the individuals' needs.
- It was also positive that the ACPs for Individual #21's UTI on 7/11/18, and Individual #77's skin breakdown to coccyx area and right buttock on 7/19/18, met criteria for quality. Unfortunately, nurses then did not complete consistent assessments to measure healing/resolution.
- Common problems with the acute care plans that were submitted included a lack of: alignment with nursing protocols; 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.
- Nurses need to modify ACPs in a way that does not include crossing out or writing in information, which makes them difficult to read and follow.
- Nursing staff should use either military time or regular time for documentation, but not both.
- Dates and times in many of the IPNs did not make sense and could not be accurately interpreted. This made it difficult to determine the sequence of events and actual timeliness of care.
- IPNs should clearly reflect if an individual was in the hospital and the note was an update from the hospital nurse's report.
- Nurses should review the PCP notes for acute issues to identify additional signs and symptoms that might require monitoring (e.g., labs findings or diagnostics, which were not addressed in some of the cases reviewed).

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

- An IPN, dated 2/9/18, at 10:46 a.m., noted that the nurse conducted an initial assessment of Individual #103's red right eye, based on direct support professional staff report. The initial assessment did not include an assessment for swelling of the eye lid, observations of whether an object was in the eye, if an injury had occurred, whether or not the individual was sensitive to light, pupil assessment of size and reaction to light, corneal involvement, and any other symptoms that were present. Directions to staff did not include preventing possible spread of infection to the left eye. The nurse properly notified the PCP.

  Individual #103 had an urgent same-day ophthalmologist appointment for a possible abrasion that the PCP noted. Based on documentation submitted, the nurse did not conduct an assessment or write an IPN prior to the appointment. Upon the individual's return, at 4:37 p.m., the nurse wrote a late entry, but did not indicate that the ophthalmologist found an abrasion. The nurse did not assess or document an assessment for swelling of the eye lid, whether or not the individual was sensitive to light, pupil size (i.e., although the note indicated that he closed his eyes when the nurse tried to assess pupil reaction), or whether any other symptoms were present. Again, directions to staff did not include preventing the individual from rubbing

his right eye and spreading infection to the left eye.

The nursing IPN, dated 2/10/18, at 2:31 a.m., noted that Individual #103 would be "reassessed every shift x3 days then daily." However, the ACP, dated 2/9/18, indicated the individual was to be assessed daily. Nursing staff had written items on the ACP, crossed items out, and written in the margins, which made the plan difficult to interpret and follow. In the goal section, the word "her" was crossed out and "him" was added. Some of the interventions were not measurable (e.g., frequent handwashing, adequate nutrition/hydration, without specific criteria). The nursing protocol for pain was included in the ACP, but not individualized. In addition, not all assessment criteria were included in the ACP (e.g., whether or not the individual was sensitive to light, vision problems, assessment of the left eye, infection control practices to prevent the spread of the infection). Although the ACP did not meet criteria, assessments in the IPNs did not consistently include the criteria listed in the ACP, such as pupils equal, round, reactive to light, and accommodation (PERRLA). In addition, the IPNs did not provide information about the individual's nutrition or intake, or vital signs. There was no documentation found resolving the ACP and the ACP did not include a date on which it was resolved.

- For Individual #61, in an IPN, dated 5/29/18, at 7:13 p.m., the nurse documented an assessment of the individual's left middle finger due to a human bite. However, the IPN indicated that the individual was crying, and when the nurse tried to apply pressure, she refused. The nurse documented vital signs, and noted the individual's blood pressure was elevated (125/99), as was her pulse (110). However, the end of the IPN indicated that Individual #61 was "in no apparent distress. Shows no signs and symptoms of pain." The nurse did not document notifying the PCP, but the PCP saw the individual and sent her to the ED for evaluation. Prior to the individual's transfer to the ED, the nurse did not document an assessment. Upon the individual's return to the Center, the nurse's assessment did not include a complete set of vital signs, a description of the finger (although the nurse noted it was bandaged, but did not indicate if the whole finger was bandaged or only the top of the finger), temperature of the skin on the individual's hand, or whether or not bruising was present.

  The ACP included some specific criteria, such as vital signs, level of consciousness, capillary refill (however, it was not clear whether or not she still had her fingernail as a result of the bite), and description of the wound with measurements. Other interventions were not specific, such as monitor reactions on Augmentin and bacitracin, wash wound (no frequency), and no frequency was included for pain assessments. The ACP indicated that nurses should complete some interventions daily during wound care, but then noted "may include but not limited to." Assessment criteria needs to be consistent in order to allow comparisons to measure the healing process.

  Although nurses referenced the individual's finger in daily IPNs, they included few assessment criteria from the ACP. Except for vital signs, nurses' assessments were inconsistent. As a result, on 6/9/18, when a nurse noted in an IPN that the issue was resolved, few IPNs were available describing the progression of healing to support this conclusion.
- A nursing IPN, dated 1/5/18, at 4:38 a.m., noted that direct support professional staff reported that Individual #108 did not have enough sleep and kept getting up. The note indicated that she had "green exudate to her eyes, which [sic] she receives treatment for, eye drops and Johnson's baby shampoo eyelid scrubs." The nurse did not conduct further assessment of her eyes and did not notify the PCP. A green discharge indicates an infection and the nurse should have reported it to the PCP and initiated infection control procedures. It was not until 1/6/18, at 7:08 a.m., that a nurse noted in an IPN that Individual #108 had swelling to the right lower lid and a large amount of green/yellow sticky exudate, and placed the individual on the list for

the PCP to see. The nurse did not complete and/or document an assessment at this time that included observations of anything in the eye, if an injury had occurred, whether or not the individual was sensitive to light, a pupil assessment of size and reaction to light, corneal involvement, and/or whether or not any other symptoms were present. On 1/7/18, IPNs made no mention of her eyes. It was not until 1/8/18, that the PCP saw her.

The ACP did not include criteria for assessing her eyes, such as itching, swelling, drainage, pupils PERRLA. The PCP note, dated 1/8/18, indicated: "Bilateral conjunctivitis due to contamination of eye drop containers most likely. Discard all current bottles of eye drops." Based on the IPNs and ACP, there was no indication that this issue was addressed.

An IPN, dated 1/9/18, at 12:41 p.m., indicated: "No treatment needed at this time related to the bilateral conjunctivitis." However, this was not accurate, as the PCP ordered antibiotic eye drops. No IPNs were found for 1/10/18; thus, nurses did not conduct and/or document any assessments of her eyes that day. Through 1/16/18, when nursing staff closed the ACP, nurses did not document in the IPNs any complete assessments of her eyes. For example, assessments did not consistently include descriptions of her eyes, PERRLA, infection control procedures implemented, any visual problems, or if swelling was present.

- An IPN, dated 3/23/18, did not indicate that nursing staff instructed staff to keep Individual #128 still and not move him, since staff found him on the floor face down, disoriented, trembling with dried blood on his mouth and on his shirt, with a golf-ball-sized bump on the left side of his head (although the IPN noted no hematoma). There was no indication that the nurse assessed him for nasal issues/fracture or breathing issues, oxygen saturation, symmetry of face, numbness or tingling, how he was showing disorientation, pain, his cardiac status and pulse, or if he was incontinent. Also, it was concerning that staff assisted him to get up and walk when the nurse had not yet assessed him. Staff should complete training regarding potential head, neck, and back injuries.

  The Monitoring Team found no nursing IPN noting the exact time when Individual #128 went to the ED. An IPN, dated 3/23/18, noted "EMS arrived at approximately 20:10, and care of the client was transferred to EMS personnel at this time." The time included in the IPN was probably an error. A nurse completed an assessment upon the individual's return to the Center. However, the nurse did not document a full neurological check. The IPN, dated 3/23/18, four hours after his return from the ED (8:16 a.m.) noted he slipped and fell on his left side while trying to enter another individual's room at a fast pace. He sustained an abrasion to the left flank region.

  On 3/27/18, at 9:28 a.m., (four days later), a nurse made a late entry for 3/23/18, at 11:05 a.m., noting Individual #128 was sent to the ED on 3/22/18, after staff found him in another individual's room with bump to left upper head area. It was unclear if this was a different incident, since the date (3/22/18) was different than the acute unwitnessed incident noted on 3/23/18. There were several discrepancies in times found in the IPNs, making it difficult to follow the sequence of events.

  In addition, an IPN, dated 3/23/18, at 11:48 a.m., noted a nurse gave him Tylenol for pain. Although the PCP ordered Tylenol on a regular schedule, the nurse should have conducted a pain assessment (i.e., a pain scale with objective measures, such as vital signs) to determine any need for changes, as well as the effectiveness of prescribed pain medication.

  The frequency of neurological assessments that the nurse included in the ACP (daily) were not in alignment with the frequency

included in the moderate head injury guidelines (every 15 minutes for one hour, then every 30 minutes for four hours, then every two hours for eight hours, then every four hours for eight hours, and then every eight hours for 48 hours or longer until the individual's neurological status is deemed stable). The ACP did not include a list of the assessment criteria for neurological checks to ensure consistency in assessments between nurses.

In addition, the PCP's IPN, dated 3/23/18, noted: "his head does show acute signs of trauma in the form of a hematoma on the left side measuring about 4 cm x 4 cm with localized swelling." It also noted that his gait was slightly abnormal and ataxic favoring his right side. The note also indicated that due to his Down Syndrome, he was at risk for atlantoaxial instability (AAI, which is characterized by excessive movement at the junction between C1 and C2, and can cause neurological symptoms when the spinal cord or adjacent nerve roots are involved). The ACP did not reflect assessments for these specific issues that the PCP noted.

Based on the assessments documented in the IPNs, nursing staff did not follow the schedule for neurological checks, and none of the assessments included full neurological check assessment criteria. Nursing staff conducted and/or documented no ongoing assessments of the hematoma noted to the left side of his head. Nursing staff conducted and/or documented no mental status exams or assessments of his gait (i.e., given that the PCP noted he was unsteady and favoring the right side). Nursing staff made no mention of his daily functioning or ability to complete tasks that he was able to do prior to this incident. Clearly, the nurses need significant training regarding head injuries, related assessments, and potential long-term effects.

In an IPN, dated 3/28/18, at 6:45 p.m., a nurse noted the ACP addressing moderate head injury would be closed since it was no longer deemed necessary. However, nurses had not conducted comprehensive assessments in alignment with a head injury, hematoma, and risk for AAI to allow a determination to be made that he was stable.

- Individual #15's ACP met most criteria, but did not include a clinically relevant, measurable goal/objective. In addition, nurses did not follow the assessment criteria included in the ACP, but did assess and document his vital signs and respiratory status.
- For Individual #68, a nurse completed a thorough initial assessment. However, it was unclear if the incident in which another individual bumped into him and fell on him, causing the fracture of the left humerus head happened on 5/15/18, per the PCP note (dated 5/16/18), or on 5/16/18, per the nurse's IPN, dated 5/16/18 at 2:55 a.m. It also was unclear when the nurse actually conducted the assessment. The ACP met most criteria, but did not include a clinically relevant, measurable goal/objective. It was positive that nurses implemented the ACP.

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 clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual has a specific goal/objective that is clinically relevant and	6%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2

	achievable to measure the efficacy of interventions.	1/18									
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	28% 5/18	0/2	0/2	2/2	1/2	0/2	0/2	0/2	1/2	1/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #103 – falls, and medication side effects; Individual #61 – constipation/bowel obstruction, and GI problems; Individual #108 – choking, and cardiac disease; Individual #128 – falls, and constipation/bowel obstruction; Individual #21 – dental, and choking; Individual #77 – falls, and seizures; Individual #15 – skin integrity, and constipation/bowel obstruction; Individual #68 – fractures, and choking; and Individual #67 – constipation/bowel obstruction, and choking).

The IHCP that included a clinically relevant, achievable, and measurable goal/objective was for: choking for Individual #68.

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #108 – choking, and cardiac disease; Individual #128 – constipation/bowel obstruction; and Individual #67 – constipation/bowel obstruction.

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 generally 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: Nurses often did not include interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them according to the criteria in the IHCPs. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. This placed a number of individuals at significant risk of harm. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67

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	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/11	0/2	0/1	0/1	0/2	N/A	0/2	0/1	N/A	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: As noted above, the Monitoring Team reviewed a total of 18 specific risk areas for nine individuals, and as available, the IHCPs to address them.

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs often 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, or that nursing interventions were implemented thoroughly. Those for which initial implementation occurred within 14 days were Individual #108's cardiac disease IHCP, and Individual #68's fractures IHCP.

One issue identified was that even when IHCPs defined individualized nursing assessments/interventions, the template that the Center used to document the completion of the assessments was not individualized. Therefore, the assessments documented did not include all of the individualized criteria that the IHCPs specified. The Center is encouraged to correct this deficit by modifying the template.

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- Although according to the ISPAs provided, Individual #103's IDT met a number of times, the IDT did not complete and/or document a comprehensive review of his specific symptoms related to his existing diagnoses, including a timeline, and analysis in comparison with medication changes and blood levels. This individual's signs/symptoms of illness created a very complicated picture, which would have benefitted from this type of analysis. In addition, in December 2017 and January 2018, practitioners at Rio Grande State Center as well as in the hospital prescribed several medication changes. While some of the medications were tapered, others, such as Lithium were abruptly discontinued, which also could have precipitated symptoms. Along with his existing diagnoses related to drug-induced health issues, he also experienced nausea, vomiting, weight loss, weight gain, excessive thirst, dysphagia, an ulcer to the right eye, tachycardia [of note, the ISPA, dated 2/6/18, indicated that the Clinic nurse did not find heart rate values in the 140 range on the vital sign record as the PNMT nurse reported during the ISPA meeting, but the PNM nurse indicated that she documented her IPNs under "Special Assessment" and not under "Medical Observations and notified the floor nurse of concerns], prolongation of the QT interval, an increase in falls, periods of hyperactivity (not trended), sleep issues that were not defined, constipation, variability regarding his articulation therapy, an intervention to increase his intake to 2200 cubic centimeters (cc) of fluids daily (for which the ISPAs, dated 4/10/18, and 4/24/18, noted documentation did not exist to support his receipt of the required fluids), lithium toxicity, hypernatremia, and nephrogenic diabetes insipidus secondary to lithium use. It was unclear from the ISPAs provided what psychiatric symptoms

Individual #103 experienced, when they occurred, how long they lasted, and any associated trends and patterns. At the time of the review, the Center did not have a psychiatrist to monitor these issues. It is imperative that the Center comprehensively review this individual's case in order to ensure his psychiatric symptoms are clearly defined, his entire medication regimen is evaluated with a plan in place to safely taper and/or increase his medications with clear justifications for use, and a structured system is in place to assess and monitor symptoms/side effects with frequent IDT review.

- Individual #61's IHCP noted that staff were to collect data on vomiting for the next six months (i.e., from 5/22/18 through 11/22/18). The specific information that staff were to document for each vomiting episode included: 1) what she was doing right before she vomited; 2) whether or not she self-induced vomiting; 3) her mood before and after vomiting; 4) whether or not she complained of feeling ill or stomach aches before vomiting, or any signs of pain; and 5) what she did after she vomited, including whether or not it seemed to relieve her distress. The IHCP noted that staff should document this information on a Service Objective data sheet, the QIDP would review it monthly, and the RNCM would review it quarterly. However, based on a review of the QIDP monthly reports and the nursing quarterlies, the QIDP and RNCM did not provide any information addressing these data. The only recent mention of the vomiting episodes was found in the ISPA, dated 7/2/18, noting that she had not had any more episodes of self-induced vomiting. No analysis was found indicating whether or not the IDT identified trends, patterns, or causes in order to prevent these episodes from reoccurring.
- On 5/3/18, during general anesthesia for dental work, Individual #108 experienced cardiac arrest. Several issues were found involving this incident and the lack of IDT action, including, for example:
    - Documentation in the nursing annual and quarterly assessments noted that Individual #108 frequently would not allow nurses to obtain her blood pressure. Since 5/24/89, she had resided at the Center, and was diagnosed with hypertension, cardiomyopathy, had an abnormal EKG showing "possible CAD [coronary artery disease]," dyslipidemia, and a significant family history of five brothers diagnosed with CAD and all having had open heart surgery before the age of 50 (per the AMA, dated 10/10/17). According to the Medication Administration Record (MAR), she was taking medication (Carvedilol and Hydrochlorothiazide) for hypertension and valsartan for "uncontrolled blood pressure." Given the serious nature of her hypertension, efforts to work with her in order to improve her willingness to allow nurses to take her blood pressures would have seemed to be a priority.

      Documentation from the nursing quarterly assessments, dated 10/23/17 through 2/28/18, and 2/28/18 through 5/23/18, noted: "No information was found for BCBA evaluation for desensitization or the SO to track BP compliance," indicating that prior to her cardiac arrest on 5/2/18, and even after the health event, the IDT had not developed strategies to gain her cooperation in monitoring one of her significant health indicators.
    - Nursing staff had not recorded blood pressures on the MARs reviewed to indicate that her blood pressure at the time of administration was within the parameters noted in the PCP's orders.
    - From the same quarterly nursing assessments noted above, regarding the goal that Individual #108 would walk to the vocational program in the morning and back in the afternoon to increase weight bearing, the documentation indicated: "Unable to determine the progress of this goal due to no documentation found." Although this was focused on weight bearing, her ability to complete this walking program also would have provided measurements of her endurance and her heart health.
    - Nursing quarterly assessments noted a lack of documentation and follow-up regarding a program addressing hygiene for preventing urinary tract infections. The presence of infections would compromise the individual's overall health

status as well as her cardiac status.
    - The IDT had not developed an IHCP to address the blood thinners she was prescribed: Eliquis and acetylsalicylic acid. Her risk for falls and her history of injuries from falls should have warranted regular assessments for bruising and bleeding, and aggressive proactive interventions to prevent her falls.
    - The documentation indicated that Individual #108 was oxygen-dependent, wore a nasal cannula, and carried an oxygen tank with her. There was no mention of who checked her oxygen tank, how often staff would check it, and/or how staff would document the findings to ensure that it did not run out of oxygen.
    - Even straining from constipation could compromise this individual's cardiac status. However, IDT discussions of these issues were not found.

  Overall, the documentation in the ISPAs provided did not reflect that the IDT reassessed Individual #108's health issues in light of her significant cardiac risks, or that the IDT approached the assessments and training that the team had identified as necessary with any urgency.
- Based on the ISPAs provided, Individual #128's IDT had not met to address his falls. The discrepancies in the fall data between different documents was concerning, and could easily lead to IDTs not addressing significant issues. His ISP IRRF did not provided specifics about dates or circumstances of his falls. However, the document TX-RG-1808-IV.1-20 noted he fell on 5/28/18, 6/26/18, 8/7/18, 8/16/18, and 8/23/18. These dates of falls were not included in the data found in the Episode Tracker the Center provided, though. Since the IDT had not analyzed his falls, they had not put preventative interventions in place. The IDT had not reviewed and analyzed factors such as medications, his anemia, blood levels, possible blood pressure drops, and two reported head injuries from peer-to-peer aggression, on 12/31/17, and 3/22/18. His increase in falls left him at significant risk for harm.
- Although the document TX-RG-1808-IV.1-20 indicated that Individual #128 had not had episodes of constipation, the Episode Tracker indicated that from 1/1/18 through 4/23/18, he had at least six episodes. Again, based on the ISPAs submitted, the IDT had not reviewed this issue. It was very concerning that reportedly changes the Center made to a protocol dictated that if an individual had not had a bowel movement for two days (as opposed to three days in the previous protocol), nurses were to administer PRN medications for constipation, rather than relying on clinical symptoms derived from a nursing assessment to determine whether or not the individual was constipated and required the intervention. Moreover, from review of Individual #128's IPNs, when nurses administered a PRN for constipation because the individual had not had a bowel movement in two days (again, rather than three days per the original protocol), they did not conduct and/or document assessments for constipation to indicate if symptoms were present or not before administering the medications. This is a significant breech in nursing standards of practice and has the potential to subject individuals to unnecessary use of medications. In addition, no indication was found to show that the IDT met to review and assess the cause(s) for the increase in the use of PRN medications for constipation.
- Although Individual #77's IDT met on several occasions, as documented in the ISPAs provided, and reviewed issues, such as fall data, hospitalizations, and weight loss, the IDT had not conducted the necessary monitoring and follow-up, and had not implemented proactive interventions for this individual who demonstrated changes in his health/behavior status. The IDT had not monitored and reviewed his neurological status, including the possibility of head injuries from all the falls and hits to his head that he experienced, or due to suspected Noonans Syndrome (an autosomal dominant congenital disorder that is characterized by issues such as heart defects, bleeding problems, and skeletal malformations). The IDT also had not fully analyzed and addressed his hearing loss, a laceration repair to his forehead in 2014, a laceration to his right eyebrow in 2016,

an increase in falls with at least 13 falls in the past ISP year, adrenocortical insufficiency (i.e., adrenal glands do not produce steroid hormones that regulate sodium, potassium, and water retention), episodes of somnolence, seizure activity on 3/23/18 (i.e., due to refusals of three days of seizure medications per the nursing quarterly assessments), a peer-to-peer "brutal beating" on 8/11/18 (according to an ISPA dated 8/13/18), a fall/drop to the floor on 8/27/18 with a laceration to his forehead, a seizure with a fall to the floor in which he hit his face on 8/29/18, a hospital admission on 8/30/18, for a prolonged seizure, and a fall out of bed in the hospital. The following issues were found:

- Nurses were not conducting neurological checks after falls, peer-to-peer aggression, and seizures.
- Discrepancies were found in the seizure data between documents and assessments.
- The IDT did not conduct a comprehensive analysis of his falls, peer-to-peer aggressions, behaviors, and hits to the head, with the development and implementation of aggressive interventions to prevent them, regardless of the severity of associated injuries.
- The IDT did not take reasonable action to protect Individual #77 from a peer that had been targeting him "multiple times this year on the following dates: 7/1/18, 7/17/18, 7/24/18, 8/2/18, and 8/11/18, that resulted in a brutal beating where he was kicked, hit and punched at least 60 times to the head, face, abdomen, and back," according to the ISPA, dated 8/13/18, and the Narrative of Events report, not dated, from staff's review of the video. The IDT's plan consisted of redirecting Individual #77 away from this peer and that he was not to be outside more than 30 minutes. The ISPA stated: "IDT agreed and will review in two weeks." This timeframe of two weeks before the IDT would meet again showed a lack of urgency to ensure necessary protections were in place, even after a peer, with a history of targeting Individual #77, beat him.
- The ISPA, dated 8/13/18, noted that it took 41 minutes for Individual #77 to receive medical/nursing assistance following the beating he sustained. The ISPA stated: "When outside, nurse took her materials/tools, but only visually checked [Individual #77]'s back." This is extremely concerning since the IPNs frequently noted that staff found him on the floor (unwitnessed and unknown cause), and he did not receive comprehensive nursing assessments in these situations.
- The IPNs indicated that on several occasions Individual #77 was wet from urine, which he slipped on and fell. Based on the documentation submitted, the IDT did not implement an intervention(s) to address this issue.
- The ISPA, dated 1/4/18, indicated that Individual #77 was in need of some clothing. The IPN, dated 8/12/18, indicated that he was being transferred to the community hospital after the peer beat him, and "There were no clothes in his wardrobe. He was getting clothes from elsewhere. There were no socks for his braces." This seemed to indicate that his basic needs were not being met.
- There was no indication that his IDT addressed an increase in his need for PRN suppositories in June 2018 (3) and July 2018 (7) (which were not listed on the TX-RG-1808-1-20 document), or that staff were consistently tracked his intake and output. This would have been important since in February 2018, he had a urinary tract infection (UTI), was noted not to be drinking enough and having constipation in March 2018, and had meal refusals and weight loss in April 2018.
- The IDT had not implemented a system to track changes in his cognition, or behaviors he exhibits that are not listed in his Positive Behavior Support Plan (i.e., fecal smearing, rolling on the ground or floor, incontinence, punching himself in the stomach) that might indicate changes in status. Although the IDT had identified some of these issues and noted them in the IPNs and ISPAs, the IDT did not appear to recognize these issues as potential symptoms that warrant prompt review and actions.

- Based on interactions with staff and document review, there is a critical lack of knowledge throughout the Center regarding Traumatic Brain Injuries. Competency-based training in this area is a significant need.

This list comprises only some of the issues found for this particular individual who is at significant risk for harm.

- As noted in the Center's own Quality Improvement Death Reviews of Nursing Services report, Individual #15's IDT had not reviewed and addressed his significant constipation problems and his diagnosis of Ogilvie Syndrome. For example, the QA nurse found: 1) a lack of nursing documentation related to the administration and effectiveness of medications ordered to relieve constipation; 2) conflicting data between the IPNs, MARs and bowel movement logs, including that the lack of IPN documentation "made it difficult to feel confident that the accuracy of the data and monitoring of BMS was meeting standards of practice"; 3) the effectiveness of the medications for constipation since October 2017 "seemed to be decreasing but appeared overlooked"; 4) the IDT did not identify or review constipation issues even though he had been to the ED for constipation and he was having multiple medication changes for constipation that were "moderately maintaining effectiveness"; and 5) aggression and behavioral trends were noted with constipation episodes since his ED visit. The association of behavior and constipation was noted in the PBSP "but it does not appear that nursing or the IDT picked up on this."

  In addition, Individual #15 did not receive nursing assessments that were consistent with applicable standards or frequent enough for a risk area that the IDT should have rated as high rather than medium. The IDT had not implemented a system to regularly review objective and subjective data in order to note subtle changes in status and provide prompt proactive interventions. In this particular case, as well as for other individuals reviewed, the IDT took action only on a reactive basis and did not follow up to ensure actions were effective. In this case, based on the review of ISPAs, Individual #15's IDT did not address his constipation/obstruction risk until on 6/14/18, he had an acute event and hospitalization due to abdominal distention and pain. Upon his discharge, no ISPAs were found showing his IDT developed/revised his plan, since his status had significantly changed due to having an ileostomy.
- In April 2017 (no specific date provided in the IRRF), Individual #67 experienced a significant choking episode. However, this significant history was not noted in the AMA or annual nursing assessment. In fact, both of these documents indicated that he did not have any choking incidents. In addition, although the goal in his IHCP reflected the SLP's observations that he talked with staff while eating, placing him at risk for choking, the intervention to monitor his meals only three times a year was not frequent enough to ensure staff consistently followed the PNMP instructions. The ISPA, dated 7/11/18, indicated that during that meeting, the IDT noted Individual #67's "TD was more prominent with the turning of his head and the mouth movements he was displaying." This ISPA indicated that his psychiatrist was changing some of his psychotropic medications and he might experience side effects, such as stiffness and fine tremors, eyes rolling backward, stiff gait, and/or shaking. The document stated that if these were to occur, he would immediately need an injection of Benadryl. However, the IDT did not develop or implement a plan for nursing staff to regularly proactively assess and monitor him during mealtimes to ensure these symptoms did not increase his risk for choking.

Outcome 6 – Individuals receive medications prescribed in a safe manner.	
Summary: For at least the past three 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	Individuals:

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.											
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual receives prescribed medications in accordance with applicable standards of care.	88% 15/17	2/2	2/2	1/2	2/2	2/2	2/2	1/1	2/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/4	0/1	N/A	0/1	N/A	N/A	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).	88% 7/8	1/1	0/1	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.	75% 3/4	1/1	N/A	0/1	N/A	N/A	1/1	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 IHCP or acute care plan should define.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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.	33% 2/6	N/A	1/1	N/A	0/1	N/A	0/1	0/1	1/1	0/1
f.	Individual's PNMP plan is followed during medication administration.	88%	1/1	1/1	1/1	1/1	1/1	0/1	N/A	1/1	1/1

		7/8									
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	88% 7/8	1/1	1/1	0/1	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.	13% 1/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	1/1	0/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	14% 1/7	0/1	0/1	0/1	0/1	N/A	N/A	0/1	1/1	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	0/1	1/1	1/1	N/A	1/1	1/1	1/1	N/A	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.	100% 2/2	N/A	1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: The Monitoring Team conducted record reviews for all nine individuals and observations of eight individuals. Individual #15 was deceased.

a. and b. Problems noted included:

- For Individual #108, the Monitoring Team had difficulty with the legibility of the MAR for insulin administration. In addition, nurses had not documented blood sugars on the MAR to justify why it was not given or the specific dose. The Center provided no explanation for why a number of MAR spaces were circled. Nurses also had not documented blood pressures on the MAR to indicate that they took them prior to administering the medication.
- For Individual #67, there was no entry on the MAR for the 7/27/18 administration of a Dulcolax 10 milligrams (mg) suppository, which was noted in the IPN, dated 7/27/18 at 12:56 p.m.
- The MARs for the following individuals included circled spaces that nurses had not explained: Individual #108, Individual #15, Individual #77, and Individual #103.

c. It was positive that during the medication administration observations for eight individuals, nurses generally followed the nine rights. The exception was that the nurse had pre-signed Ativan on the narcotics sheet prior to administering it to Individual #61.

d. For most of the applicable individuals, medication nurses completed respiratory assessments consistent with the individuals' needs. The exception was that Individual #108's IHCP included an action step for nursing staff to complete and document lung sounds. However, nurses had not documented their completion at the frequency identified in the IHCP.

e. For the individuals reviewed, nursing assessments often were not documented prior to the administration of PRN medications.

f. For the individuals the Monitoring Team observed, nursing staff generally followed the PNMPs. The exception was for Individual #77, for whom the picture on the PNMP was too small to ensure correct positioning for medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices. The exception was that during Individual #128's medication administration observation, one of the drawers in the medication cart had a spilled yellow substance in it that staff had not cleaned.

h. For the records reviewed, evidence was generally not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed. This showed regression since the Monitoring Team's last review. At times, this placed the individual at significant risk. For example, on 5/11/18, Individual #108 began taking Eliquis for a deep vein thrombosis (DVT) to the right arm. It is a blood thinner and placed the individual at risk for bruising and bleeding. In addition to nurses not documenting instructions to the individual and staff, the IDT did not develop an IHCP addressing the risk.

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

l. and m. On the variance form for Individual #103, dated 1/26/18, nurses did not indicate how many doses he received of the wrong medications.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Improvements are needed with regard to IDTs referring individuals to the PNMT, when needed, and/or the PNMT making self-referrals. In addition, overall, IDTs and/or the PNMT did not have a way to measure clinically relevant outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
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;	18% 2/11	N/A	0/1	1/2	0/2	0/2	N/A	0/2	1/1	0/1

	ii. Individual has a measurable goal/objective, including timeframes for completion;	18% 2/11		0/1	1/2	0/2	0/2		0/2	1/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	9% 1/11		0/1	1/2	0/2	0/2		0/2	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/11		0/1	0/2	0/2	0/2		0/2	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/11		0/1	0/2	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;	38% 3/8	1/2	0/1	N/A	N/A	N/A	1/2	N/A	1/1	0/1
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	13% 1/5	0/2	0/1				1/2		0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	38% 3/8	1/2	0/1				2/2		0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8	0/2	0/1				0/2		0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/8	0/2	0/1				0/2		0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/8	0/2	0/1				0/2		0/1	0/1

Comments: The Monitoring Team reviewed 11 goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: aspiration for Individual #61; choking, and falls for Individual #108; choking, and falls for Individual #128; choking, and falls for Individual #21; falls, and aspiration for Individual #15; choking for Individual #68; and choking for Individual #67.

a.i. and a.ii. The IHCPs that included clinically relevant, and achievable goals/objectives were for: falls for Individual #128, and choking for Individual #68. Individual #68's goal was also measurable. In some cases, IDTs moved in the right direction with regard to identifying the underlying cause of the PNM concern, but as written the goals/objectives did not make sense clinically (e.g., Individual #128, Individual #21, and Individual #67 had goals/objectives that appeared to target slowing their eating paces and/or prevent overfilling their mouths, but the wording of the goals/objectives did not provide a clear path for achieving that outcome).

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: choking for Individual #108.

b.i. The Monitoring Team reviewed eight areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: weight, and aspiration for Individual #103, falls for Individual #61, aspiration, and weight for Individual #77, fractures for Individual #68, and aspiration for Individual #67.

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

- For Individual #103, according to the RN quarterlies and the IRRF, the first evidence of weight loss greater than 10% occurred between June 2017 (131 pounds) and 11/17/17 (111 pounds) with weight loss continuing to 107 pounds (i.e., on 12/13/17), although some weights varied depending on the source. For example, the PNMT review cited weight loss of 10 pounds in one month (11/3/17 = 121 pounds to 11/29/17 = 111 pounds). It was difficult to determine when the IDT referred him to the PNMT. The PNMT meeting notes, dated 12/5/17, stated that formal referral was pending.
- From 12/13/17 to 12/29/17, Individual #103 was hospitalized for "healthcare associated pneumonia" and volume depletion. On 1/4/18, an MBSS indicated severe dysphagia and silent aspiration. Records identified aspiration associated with pneumonia. On 12/29/17, the PNMT RN completed the post-hospitalization review, and stated that due to the diagnosis of possible aspiration and undetermined weight loss, she recommended referral to PNMT for further assessment. However, it was not until 1/9/18, that the referral occurred.
- Although fall data was not reliable, records indicated that Individual #61 fell four times in March 2018, six times in May 2018, once in July 2018, and six times in August. Although the audit tool provides a list of criteria that requires referral to the PNMT, it qualifies that list by stating: "Appropriate referral for assessment is defined at a minimum according to the following qualifying event/threshold…" (emphasis added). IDTs still need to refer or the PNMT needs to make self-referrals of individuals who otherwise are at significant risk due to PNM issues. Over several months, this individual's falls continued to place her at significant risk of harm. At a minimum, the PNMT should have conducted a review.
- On 4/27/18, Individual #77 was referred to the PNMT for unplanned weight loss, occurring between 4/2/18 (i.e., 141 pounds) and 4/19/18 (i.e., 129.5 pounds). This was reported as a 9%-loss in one month (i.e., but was actually an 8% loss). The referral date varied depending on the source. Between 4/3/18, and 4/17/18, he was hospitalized, and refused to eat much of the time. Reportedly, three days into the hospitalization, he developed aspiration pneumonia. Staff reported that his positioning was very poor. The PNMT report did not describe aspiration pneumonia as a reason for referral, but there was reference to it in meeting minutes.
- For Individual #67, on 2/1/18, the PNMT RN conducted a post-hospitalization review for his admission from 1/26/18 to 1/27/18 for acute vomiting. He was treated for a GI-intra-abdominal infection. As is discussed in more detail with regard to the assessment process, various members of the PNMT and IDT were involved in determining the head-of-bed elevation that the individual required. The lack of a PNMT review and coordination among these therapists led to confusion about the supports he required.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT developed a clinically relevant, achievable, and measurable goal/objective for weight for Individual #77 (i.e., consuming 90% to 100% of his meals and snacks for the next three months).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: weight for Individual #103, and aspiration for Individual #77.

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 generally were not available to IDTs. As a result of the lack of data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. Due to the inability to measure clinically relevant outcomes for individuals, the Monitoring Team conducted full reviews of all nine individuals' PNM supports.

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

Summary: Improvement was noted in the information sharing between the PNMT and IDT, when the PNMT discharged an individual. However, significant concerns were noted with regard to IDTs' responses to changes in individuals' PNM status, which placed individuals at significant risk of harm. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 103	61	108	128	21	77	15	68	67
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	11% 2/18	0/2	0/2	0/2	1/2	1/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	10% 1/10	1/2	0/2	N/A	0/1	N/A	0/2	0/1	0/1	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.	100% 2/2	2/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were for choking for Individual #128, and choking for Individual #21.

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

- Although Individual #61's IDT continued to discuss menses pain and discomfort and her vomiting episodes, they never graphed data to determine if there was any correlation between her menses and behavioral episodes or vomiting episodes. In addition, the IDT had not determined whether the vomiting was "self-induced" or related to another cause.
- The status of Individual #128's falls was unclear. In one place, his IRRF stated that he was at low risk based on the guidelines. His IDT designated him at medium risk, which was more appropriate. In the calendar year prior to his most recent ISP, he reportedly had only two falls, but the IRRF later identified that he had six or seven. It stated that he had no serious injuries, and

yet, in a subsequent sentence, stated that he should be at medium risk due to falls and "head injuries" he recently had. In March 2018, he was found in a peer's room lying on the floor face down. He was bleeding from his mouth and had a bump on the left side of his head. A peer indicated he had pushed Individual #128. However, overall, the etiology(ies) of his falls was unclear. He had shoe inserts, but it was unclear whether these were intended to prevent falls, and, if so, how they related to the etiology(ies) of his falls. An action step in his IHCP, dated 5/8/18 read: "Will be moved to El Paisano to La Paloma due to his falls and ER visits." However, it was unclear how the move would assist in preventing falls.

- For Individual #77, the IDT did not develop and/or revise his IHCP for weight after his first hospitalization. They did not update it until after the PNMT completed its assessment, almost two months after the first identification of weight loss. Actions should have been documented in the plan.
- During the onsite review week, Individual #77's IDT held an ISPA meeting, after a series of seizures and falls with head injuries. After his first head injury, the IDT took no action, and while the Monitoring Team was onsite, the meeting was initially intended to discuss his level of supervision, rather than the impact of his recent head injuries and sudden seizure activity. The IDT had not updated/revised the IHCP, conducted appropriate assessments, and/or initiated interventions. The PT indicated that she was providing direct therapy twice weekly and that he was making progress, but the documentation did not support these statements. As discussed elsewhere, in July 2018, the PT assessment related to falls was incomplete.
- On 5/15/18, at around 5:45p.m., Individual #68 fell and sustained an injury to his left arm. Shortly after midnight, based on x-ray results, the PCP was notified that the individual had a humeral fracture. On 5/31/18, the individual had an ORIF done on his left shoulder and returned to Center. On 5/27/18, after he sustained the fracture and before it was repaired, he fell again. Despite these falls and a serious injury, his IDT did not revise his IHCP to include preventative interventions.

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, including Habilitation Therapies as well as Residential and Day Program/Vocational staff, 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.	48% 25/52	
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.	14% 1/7	
Comments: a. The Monitoring Team conducted 52 observations of the implementation of PNMPs. Based on these observations,			

individuals were positioned correctly during three out of seven observations (43%). Staff followed individuals' dining plans during 21 out of 41 mealtime observations (51%). Staff completed transfers correctly during one out of four observations (25%).

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A									
Comments: a. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed received total or supplemental enteral nutrition.											

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: None of the individuals reviewed had clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/10	0/1	0/1	0/1	0/1	N/A	0/3	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/10	0/1	0/1	0/1	0/1		0/3	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/10	0/1	0/1	0/1	0/1		0/3	0/1	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/10	0/1	0/1	0/1	0/1		0/3	0/1	0/1	0/1

e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/10	0/1	0/1	0/1	0/1		0/3	0/1	0/1	0/1

Comments: a. and b. None of the individuals reviewed had clinically relevant, and measurable goals/objectives to address their needs for formal OT/PT services.

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

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.

Summary: For the individuals reviewed, evidence was not found to show that OT/PT supports were implemented. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	N/A	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.	N/A									

Comments: a. There was a lack of evidence in integrated ISP reviews that supports were implemented. In addition, the Monitoring Team reviewed data from the PT/OT, which did not show full implementation of direct therapy supports. For example:

- During an onsite meeting related to individual #77, the PT indicated that she was providing direct therapy twice weekly and that he was making progress, but the documentation did not support these statements. In fact, documentation showed that the individual refused to interact with the therapist on a number of occasions, and no documentation was found of the actual provision of direct therapy.
- For Individual #68, the Center did not submit QIDP monthly summaries after May 2018. In addition, no documentation was found of progress related to measurable goals with specific outcomes. The OT was supposed to see him twice a week for eight weeks, but the OT saw him twice a week for four weeks, and once per week for four weeks. The recommendations continued to state twice per week for eight weeks, so it was not clear what the plan was moving forward. All progress notes were late entries.

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

Summary: Since the last review, improvement was seen with regard to the

cleanliness, as well as the working condition of adaptive equipment. Substantial work is needed, however, with regard to ensuring the proper fit of individuals' adaptive equipment. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	77	140	71	124	85	114			
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	86% 6/7	0/1	1/1	1/1	1/1	2/2	1/1			
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 7/7	1/1	1/1	1/1	1/1	2/2	1/1			
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	29% 2/7	0/1	1/1	0/1	0/1	0/2	1/1			

Comments: a. The Monitoring Team conducted observations of seven pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment, which was good to see. The exception was Individual #77's wheelchair. When the Monitoring Team member observed him during mealtime, his clothes were covered with grass and leaves and these were also all over his wheelchair. His wheelchair was wet from urine. Staff required prompting to take him to his room to assist him with these hygiene issues.

b. The equipment observed appeared to be in working order.

c. Based on observation of Individual #77, Individual #71, Individual #85 (activity chair), and Individual #85 (wheelchair) in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

Of note, Individual #140 wore her gait belt even when staff were not assisting her with ambulation or transfers. The reason for this was unclear.

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, two indicators were moved the category of requiring less oversight. For this review, no other indicators will be moved to this category.

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 the ISPs, given that all but one of the goals did not meet criterion with all three ISP indicators 1-3 (individualized, measurable, and data available), progress could not be determined. The one goal that met criteria with these indicators was progressing, which was good to see.

Moreover, many action steps were not consistently implemented for each individual. Staff present in individuals' homes were frequently aware of individuals' preferences, but often unfamiliar with their personal goals. This was partially understandable because so many of the action plans had not been developed for implementation.

Fewer SAPs met criteria for content when compared with the last review. Many components were in the SAPs, but three-quarters of the SAPs were missing one or more components.

The majority of SAPs did not have data, or the data were not summarized or graphed, making objective decisions concerning the continuation, revision, or discontinuation of SAPs impossible.

Rio Grande SC was not checking the quality of the implementation of SAPs (i.e., their integrity). Moreover, the Monitoring Team attempted to observe four SAPs, but was unable to do so due to individuals not being available or refusing to participate.

Monitoring Team's direct observations of individuals and of Center engagement data found that none of the individuals were consistently engaged.

Rio Grande SC interim management was aware of the need for improvements in the number and range of activities to be made available to individuals. Management was working on various activities, settings, and instructions for staff to increase this. For instance, there was a new clubhouse, library, movie room, auditorium availability, swimming pool, and art room in La Paloma home; and it was easier to now arrange for community outings. The Monitoring Team recommends that the Center develop some method to measure Center-wide participation in these rooms, activities, and opportunities.

One individual reviewed had a communication goal/objective that was clinically relevant, as well as measurable. Unfortunately, the original goal was not included in the individual's ISP. Although the QIDP reports did not include all of the necessary information and analysis, the SLP documented progress in communication IPNs and indicated that the individual met criteria. In an ISPA meeting, the IDT modified the goal.

It was concerning that often when opportunities for using individuals' AAC devices presented themselves, staff did not prompt individuals to use them. The Center should focus on improvements in this area.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that all but one of the goals did not meet criterion with all three ISP indicators 1-3 (individualized, measurable, and data available), the indicators of this outcome also did not meet criteria. The one goal that met criteria with these indicators was progressing, which was good to see. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	103	61	150	77	68			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	1/6	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 and implementing actions plans that clearly support the achievement of those personal goals, and thus, the facility can achieve compliance with this outcome and its indicators.

4-7. A personal goal that meets criterion for Indicators 1 through 3 is a pre-requisite for evaluating whether progress has been made. For these six individuals there was no basis for assessing progress as the IDTs failed to collect reliable and valid data for any personal goals, with one exception.

The single exception was the living options goal for Individual #115. It was positive he had made progress in this goal area, but the IDT did not provide valid and reliable data to indicate progress in the other areas. Overall, the Monitoring Team continued to find a lack of

consistent implementation.

Outcome 8 – ISPs are implemented correctly and as often as required.												
Summary: These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	115	103	61	150	77	68				
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. The Monitoring Team's evaluation of this indicator is based on observations, interviews, and review of documentation that reflects implementation. Overall, none of six ISPs had documentation that reflected consistent implementation.

Staff present in individuals' homes were frequently aware of individuals' preferences, but often unfamiliar with their personal goals. This was partially understandable because so many of the action plans had not been developed for 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. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
6	The individual is progressing on his/her SAPs.	0% 0/16	0/3	0/3	0/2	0/1	0/3	No SAPs	0/3	No SAPs	0/1
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	No SAPs	N/A	No SAPs	N/A
8	If the individual was not making progress, actions were taken.	N/A	N/A	N/A	N/A	N/A	N/A	No SAPs	N/A	No SAPs	N/A
9	(No longer scored)										

Comments:
6. No SAPs were scored as progressing. Center data for Individual #115's clearing the table SAP appeared to be progressing, however, it was scored as 0 because the data were not demonstrated to be reliable (see indicator #5).

Five SAPs (e.g., Individual #92's ride the bicycle SAP) did not have any SAP data available and, therefore, were not scored for this indicator.

Lastly, 10 SAPs had only raw data that were not summarized (e.g., Individual #30's make pizza crust SAP) and were not demonstrated to be reliable.

Outcome 4- All individuals have SAPs that contain the required components.

Summary: Fewer SAPs met criteria for content when compared with the last review. Many components were in the SAPs, but three-quarters of the SAPs were missing one or more important components. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
13	The individual's SAPs are complete.	25% 4/16	0/3 26/30	1/3 28/30	0/2 17/20	0/1 9/10	2/3 29/30	No SAPs	1/3 28/30	No SAPs	0/1 6/10

Comments:

13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning.

Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

Four of the SAPs were judged to be complete (i.e., Individual #92's ride bike SAP, Individual #127's press 9 and 1 SAP, and Individual #38's turn on the computer, and answer question SAPs).

Even so, all of the SAPs contained the majority of these components. For example, 100% of the SAPs had a plan that included:

- a task analysis (when appropriate),
- behavioral objectives
- relevant discriminative stimuli,
- specific consequences for incorrect responses, and documentation methodology
- documentation methodology
- 15 of 16 SAPs had individualized consequences for correct responses (which was an improvement from the last review)

Regarding common missing components:

- The most common missing component was the absence of clear SAP training instructions. For the majority of the multiple step SAPs, the training instructions did not clearly indicate if training should occur on one step or multiple steps at each training session (e.g., Individual #38's wash hands SAP).
- Another common missing component involved how the objectives were calculated. Many SAPs (e.g., Individual #127's wash

tomatoes SAP) counted each step as a trial. Each training session should be counted as one training trial.

- Most of the SAPs listed both staff instructions and individual skills in the skill steps section of the SAP training sheet. For example, Individual #30's make a pizza crust SAP include the first step under skill steps as "Prompt Individual #30 to make a pizza." Skill steps should only include the steps the individual needs to do (task analysis), instructions for staff such as how to prompt, when to prompt, what steps the individual should be attempting, which steps the staff should be scoring, etc. should be under the Teaching Instructions section of the SAP training sheet.

Regarding other missing components:

- Some SAPs, for example Individual #44's wash hands SAP, did not include a clear plan for maintenance.
  - A complete plan for maintenance should include a plan for how a mastered skill will be maintained once training is completed.
- Some SAPs did not include operational definitions of the task. For example, Individual #127's identify coins SAP did not specify how Individual #127 should identify the coins (e.g., point to them, say them, pick them up, etc.).

Outcome 5- SAPs are implemented with integrity.

Summary: Rio Grande SC was not checking the quality of the implementation of SAPs (i.e., their integrity). Moreover, the Monitoring Team attempted to observe four SAPs, but was unable to do so due to individuals not being available or refusing to participate. This can also be an indicator of lack of implementation. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 115	92	30	103	38	61	127	150	44
14	SAPs are implemented as written.	N/A	Attempted	Attempted	N/A	N/A	N/A	No SAPs	Attempted	N/A	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% 0/16	0/3	0/3	0/2	0/1	0/3	No SAPs	0/3	No SAPs	0/1

Comments:

14. The Monitoring Team was scheduled to observe the implementation of Individual #115's clear tables SAP, Individual #92's touch her toes SAP, and Individual #127's dial 9 and 1, and wash tomatoes SAPs. None of the SAPs scheduled occurred and as a result, the Monitoring Team was unable to observe implementation of any SAPs during the onsite week.

15. At the time of the onsite review, Rio Grande SC had established a specific schedule of SAP integrity (e.g., each SAP assessed at least once every six months), however, none of the SAPs had any SAP integrity measures. The only way to ensure that SAPs are implemented as written is to conduct regular SAP integrity checks. Ensuring that SAPs are written and scored with integrity should be a priority for the facility.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Rio Grande was not sufficiently reviewing the status of SAPs and was not creating useful graphic summaries of the individual's performance. These two indicators will remain inactive monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
16	There is evidence that SAPs are reviewed monthly.	19% 3/16	1/3	1/3	1/2	0/1	0/3	No SAPs	0/3	No SAPs	0/1
17	SAP outcomes are graphed.	6% 1/16	1/3	0/3	0/2	0/1	0/3	No SAPs	0/3	No SAPs	0/1

Comments:
16. Three SAPs (e.g., Individual #115's clear the table SAP) had evidence of regular reviews that were data based. Several SAPs were not reviewed (e.g., Individual #30's use the computer SAP), or did not have SAP data for review (Individual #103's prepare pizza SAP).

17. Individual #115's clear the table SAP had graphed data.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: Rio Grande SC interim management was aware of the need for improvements in the number and range of activities to be made available to individuals. Management was working on various activities, settings, and instructions for staff to increase this. For instance, there was a new clubhouse, library, movie room, auditorium availability, swimming pool, and art room in La Paloma home; and it was easier to now arrange for community outings. The Monitoring Team recommends that the Center develop some method to measure Center-wide participation in these rooms, activities, and opportunities. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
18	The individual is meaningfully engaged in residential and treatment sites.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	33% 3/9	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1	0/1

Comments:
18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team did not find any individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). This represents a decrease from the last review when 44% of the individuals were found to be engaged.

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. Three individuals Individual #115, Individual #103, and Individual #150 achieved Rio Grande SC's residential goal level engagement level (65%).

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: It was good to see that individuals had opportunities to go into the community. Some organizational efforts are necessary to meet the specific criteria of these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	115	92	30	103	38	61	127	150	44
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22-24. There was evidence that all of individuals participated in community outings, however, there were no established goals for this activity.

The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal is achieved.

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: Rio Grande SC was not integrating the IEP and ISP as per the criteria and sub-indicators of this indicator. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	30								
25	The student receives educational services that are integrated with	0%	0/1								

	the ISP.	0/1										
Comments: 25. Individual #30 attended school until June 2018. In order evaluate this indicator, Individual #30's 11/16/17 ISP, and his last six months of ISPAs were reviewed. His educational services were not integrated into his 11/16/17 ISP or recent ISPs.												

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: N/A			Individuals:									
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67	
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A										
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A										
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A										
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A										
e.	When there is a lack of progress, the IDT takes necessary action.	N/A										
a. through d. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed refused dental care.												

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: Work is still needed to improve the clinical relevance of communication goals/objectives, and to develop and implement communication goals/objectives for individuals who need them. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.			Individuals:									
#	Indicator	Overall Score	103	61	108	128	21	77	15	68	67	
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	17%	1/2	N/A	N/A	0/1	0/1	0/1	0/1	N/A	N/A	

	and achievable to measure the efficacy of interventions.	1/6									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	17% 1/6	1/2			0/1	0/1	0/1	0/1		
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/5	0/1			0/1	0/1	0/1	0/1		
d.	Individual has made progress on his/her communication goal(s)/objective(s).	20% 1/5	1/1			0/1	0/1	0/1	0/1		
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	20% 1/5	1/1			0/1	0/1	0/1	0/1		

Comments: a. through e. Individual #61, Individual #68, and Individual #67 had functional communication skills. They were all part of the core group, so full reviews were conducted for them. Individual #108 had not shown interest in the SLP's numerous attempts over multiple years to introduce AAC devices. She still required communication assessment and supports, though, so a full review was conducted.

The goal/objective that was clinically relevant, as well as measurable was Individual #103's goal/objective related to producing /p, b, m/ words with 70% accuracy spontaneously using picture cards. Unfortunately, the original goal was not included in the individual's ISP. Communication IPNs documented progress and indicated that he had surpassed criteria in February and April, and fell below in May. By August, he met criteria, and per an ISPA, dated 8/11/18, the IDT modified the goal.

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	103	61	108	128	21	77	15	68	67
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	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.	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.

- The SLP documented progress in communication IPNs and indicated that Individual #103 had surpassed criteria in February and April, and fell below in May. By August, he met criteria, and per an ISPA, dated 8/11/18, the IDT modified the goal. The QIDP copied the SLPs IPNs into monthly summaries. The SLPs notes presented specific data and recommended continued therapy. This was present in QIDP monthly summaries for January/February (i.e., done together), March, April, and May. Unfortunately, though, it was not present for June or July.

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 continue to focus on ensuring individuals have their AAC devices with them. Most importantly, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	144	62	29	74					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	75% 3/4	1/1	1/1	1/1	0/1					
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	25% 1/4	0/1	0/1	1/1	0/1					
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	25% 1/4									
Comments: a. and b. Individual #74's device was on the table, but he could not reach it. It was concerning that often when opportunities for using individuals' AAC devices presented themselves, staff did not prompt individuals to use them.											

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. Based on information the Center provided, between the time of the Monitoring Team's last review and the Tier I document request, none of the individuals at Rio Grande SC transitioned to the community, and no post-move monitoring occurred. As a result, the outcomes and indicators in Domain #5 were not scored.

At the time of the onsite review week, three individuals were in the active referral process. One individual was scheduled to transition in September 2018, one in October 2018, and one was in the process of learning about different providers.

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: N/A			Individuals:									
#	Indicator	Overall Score										
1	The individual's CLDP contains supports that are measurable.	N/A										
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	N/A										
Comments: None.												

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	N/A										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	N/A										
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	N/A										

	justification is provided as to why it is no longer necessary.											
6	The PMM's assessment is correct based on the evidence.	N/A										
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	N/A										
8	Every problem was followed through to resolution.	N/A										
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A										
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A										
Comments: None.												

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
N	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.	N/A										
Comments: None.												

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: N/A			Individuals:									
#	Indicator	Overall Score										
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	N/A										
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	N/A										

	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.											
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.	N/A										
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	N/A										
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	N/A										
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	N/A										
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.	N/A										
19	Pre-move supports were in place in the community settings on the day of the move.	N/A										
Comments: None.												

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score										
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	N/A										
Comments: None.												

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.
    - HHSC PI 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 HHSC PI 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
HHSC PI	Health and Human Services Commission Provider Investigations
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