United States v. State of Texas

Monitoring Team Report

Rio Grande State Center

Dates of Remote Virtual Review: November 15-18, 2021

Date of Report: February 10, 2022

Submitted By:	Alan Harchik, Ph.D., BCBA-D Maria Laurence, MPA Independent Monitors
Monitoring Team:	Helen Badie, M.D., M.P.H, M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Marlenia Overholt, B.S., R.N. Gary Pace, Ph.D., BCBA-D Teri Towe, B.S. Scott Umbreit, M.S. Rebecca Wright, MSW

Table of Contents

Background 3
Methodology 3
Organization of Report 5
Executive Summary 6

Status of Compliance with Settlement Agreement
- Domain 1 6
- Domain 2 19
- Domain 3 71
- Domain 4 128
- Domain 5 137

Appendices
- A. Interviews and Documents Reviewed 152
- B. List of Acronyms 160

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 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.

In addition, the parties set forth 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.

For this review, this report summarizes the findings of the two Independent Monitors, each of whom have 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 Center'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 review, the Monitoring Teams requested various types of information about the individuals who lived at the Center 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 Center's compliance with all provisions of the Settlement Agreement.

b. **Onsite review** – Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Teams attended various meetings via telephone, such as Center-wide meetings [e.g., morning medical, unit morning, Incident Management Review Team (IMRT), Physical and Nutritional Management Team (PNMT)], and individual-related meetings [e.g., Individual Support Plan meetings (ISPs), Core teams, Individual Support Plan addenda meetings (ISPAs), psychiatry clinics]. In addition, the Monitoring Teams conducted interviews of various staff members via telephone (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator). Also, the Monitoring Teams met with some groups of staff via telephone (e.g., Psychiatry Department, Behavioral Health Services Department). This process is referred to as a remote review.
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 Center-wide documents. During the week of the remote review, the Monitoring Team requested and reviewed additional documents.
d. **Observations** – Due to the nature of the remote review, the Monitoring Team could not complete some observations (i.e., as discussed above, some observations of meetings were possible). As a result, some indicators could not be monitored or scored. This is noted in the report below.
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 move to the category of requiring less oversight. At the next review, indicators that move to this category will not be monitored, but may be monitored at future reviews if the Monitor has concerns about the Center'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 Center'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 Center'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. 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.
g. **Quality improvement/quality assurance:** The Monitors' report regarding the monitoring of the Center's quality improvement and quality assurance program is provided in a separate document.

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Rio Grande SC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the remote review. The Center 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, and their time and efforts are much appreciated.

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 contains 14 outcomes and 43 underlying indicators in the areas of restraint management, pretreatment sedation/chemical restraint, mortality review, and quality assurance.

- The Center achieved substantial compliance with the requirements of Section D of the Settlement Agreement related to abuse, neglect and incident management.
    - As a result, the Center exited from Section D of the Settlement Agreement. This resulted in the removal of 10 outcomes, and 23 underlying indicators.
- At the last review, three indicators were moved to the category of requiring less oversight. For this review, one additional indicators will move to the category of less oversight, in the area of restraint.

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

Restraint

There was an increase in the usage of crisis intervention restraint and in the number of individuals who had one or more crisis intervention restraints each month. The Center, however, was engaging in thoughtful review of the occurrences, implementation of restraint, and their data.

Some of the zero scoring was due to improper documentation and some of it due to improper implementation of all programming interventions. For more than half of the restraints, there should have been a recommendation for inservice or monitoring, but wasn't.

For two of the four restraints reviewed, nurses performed timely physical assessments, and documented whether individuals sustained any restraint-related injuries or other negative health effects. For the remaining two restraints, staff did not notify nursing staff during or immediately following the restraints. This same problem was identified in the last report. Once staff discovered the restraints, nursing staff did not conduct vital sign assessments for either individual.

Abuse, Neglect, and Incident Management

Rio Grande SC achieved and maintained substantial compliance, such that the Center was exited from monitoring of this area, its outcomes, and indicators.

Other
For pretreatment sedation, Rio Grande SC IDTs did not address all of the required content, however, they did develop and implement procedures to address the need for the usage of PTS for all individuals.

The Drug Utilization Evaluations (DUEs) submitted did not have clear clinical relevance to individuals supported by the Center. In addition, follow-up was not documented for the one DUE that included recommendations.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.												
Summary: There was an increase in the usage of crisis intervention restraint and in the number of individuals who had one or more crisis intervention restraints each month. The Center, however, was engaging in thoughtful review of the occurrences, implementation of restraint, and their data. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	148	70	51	38						
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	75% 9/12	This is a facility indicator.									
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	82% 9/11	1/1	0/1	1/1	0/1						

Comments:
1. Twelve sets of monthly data provided by the facility for the past nine months (January 2021 through September 2021) were reviewed. Overall, there was an increase in the usage of crisis intervention restraints at the Center. There were many behavioral episodes during which a number of consecutive crisis intervention restraints were implemented (sometimes because the staff could not maintain the restraint and had to let go and re-apply, and sometimes because staff did not implement the restraint completely). The Center also submitted a graph of the monthly frequency of episodes. This also showed an increasing trend over the review period. However, the Center also submitted graphs showing the frequency of occurrence and frequency of episodes through November 2021, showing a decrease in the most recent two months (October and November 2021).

All crisis intervention restraints were crisis intervention physical restraints. The average duration of each crisis intervention physical restraint was low at about two minutes. There were no occurrences of the use of crisis intervention chemical restraint or crisis intervention mechanical restraint. There were no instances of injury to individuals during crisis intervention restraint. There was no usage of protective mechanical restraint for self-injurious behavior.

There was, however, an increasing trend in the number of individuals who had one or more crisis intervention restraints each month, to about six. There was little usage of pretreatment sedation, though more so than at the last review because more individuals were now going to medical appointments and/or having medical procedures implemented.

Note: Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement.

The Monitoring Team observed the meeting of the restraint reduction committee. It was led by the director of behavioral health services. Data were presented and there was thoughtful discussion about restraint usage, data, and areas for improvement.

In summary, the Center data showed low/zero usage and/or decreases in nine of these 12 facility-wide measures (i.e., use of crisis intervention chemical and mechanical restraint; duration of crisis intervention physical restraint; use of protective mechanical restraint for self-injurious behavior; injuries during restraint; use of non-chemical restraints for medical/dental procedures; and use of pretreatment sedation for dental procedures, and usage of TIVA/GA).

2. Two of the individuals reviewed by the Monitoring Team was subject to crisis intervention restraint. Two other individuals were also included in the review of restraints. All four received crisis intervention physical restraint. For two of the four individuals, there was low or decreasing usage of crisis intervention restraint. The other seven 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: Four of the indicators scored 50% or lower. Some of this was due to improper documentation and some of it due to improper implementation of all programming interventions. Indicator 11, however, showed sustained high performance and will be moved to the category of requiring less oversight. The other four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	148	70	51	38					
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.	50% 2/4	0/1	1/1	1/1	0/1					

6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
7	There was no injury to the individual as a result of implementation of the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	25% 1/4	0/1	0/1	1/1	0/1					
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/2		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.	25% 1/4	0/1	0/1	1/1	0/1					
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 4/4	1/1	1/1	1/1	1/1					

Comments:
The Monitoring Team chose to review four restraint incidents that occurred for four different. Of these, all were crisis intervention physical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SC utilized restraint and the SC's efforts to reduce the use of restraint.

5. For Individual #148 6/11/21, the debriefing document indicated that there was no immediate risk. For Individual #38 9/6/21, the restraint checklist noted that he was screaming and yelling and that was the behavior that preceded the restraint. But in the debriefing (done a week later) it was reported he was punching clients and staff.

8. For Individual #148 6/11/21, the debriefing document indicated it was used for the convenience of staff.

For Individual #70 8/24/21, the video review (described in the restraint ISPA) noted that no one used the Ukeru pads and there were four pads in the room. While the actual restraint was an approved method, the absence of Ukeru pad use may be an indication restraint was used for the convenience of staff.

For Individual #38 9/6/21, the restraint checklist reported that screaming and yelling preceded restraint usage. However, post-restraint review documentation described a more comprehensive and clearer picture of what preceded the restraint. From this, he presented imminent danger, but this information needs to be included in the restraint checklist.

9. For both individuals, some aspects of programming was missing to reduce the likelihood of behaviors occurring that led to restraint, such as engagement in activities, and implementation of strategies to reduce the need for using restraint during the behavior occurrence.

10. Absence of proper documentation and/or usage of less restrictive measures before restraint implementation resulted in the zero scores for three of the four restraints.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.												
Summary:			Individuals:									
#	Indicator	Overall Score										
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
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: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	148	70	51	38					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	75% 3/4	0/1	1/1	1/1	1/1					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A									
Comments: 13. For Individual #148 6/11/21, some aspects of the documentation were completed incorrectly. There was an error in the date on the ISPA.											

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 two of the four restraints reviewed, nurses performed timely physical assessments, and documented whether individuals sustained any restraint-related injuries or other negative health effects. For the remaining two restraints, staff did not notify nursing staff during or immediately following the restraints. This same problem was identified in the last report. Once discovered, nursing staff did not conduct vital sign assessments for either individual. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	148	70	51	38					
a.	If the individual is restrained using physical or chemical restraint, nursing assessments (physical assessments) are performed in alignment with applicable nursing guidelines and in accordance with the individual's needs.	50% 2/4	0/1	1/1	0/1	1/1					
b.	If the individual is restrained using PMR-SIB:										
	i. A PCP Order, updated within the last 30 days, requires the use of PMR due to imminent danger related to the individual's SIB.	N/A									
	ii. An IHCP addressing the PMR-SIB identifies specific nursing interventions in alignment with the applicable nursing guideline, and the individual's needs.	N/A									
	iii. Once per shift, a nursing staff completes a check of the device, and documents the information in IRIS, including: a. Condition of device; and b. Proper use of the device.	N/A									
	iv. Once per shift, a nursing staff documents the individual's medical status in alignment with applicable nursing guidelines and the individual's needs, and documents the information in IRIS, including: a. A full set of vital signs, including SPO2; b. Assessment of pain; c. Assessment of behavior/mental status; d. Assessment for injury; e. Assessment of circulation; and f. Assessment of skin condition.	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 1/4	0/1	1/1	0/1	1/1					
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/3	0/1	1/1	0/1	N/A					

Comments: The restraints reviewed included those for: Individual #148 on 6/11/21 at 9:26 p.m., Individual #70 on 8/24/21 at 1:19 p.m., Individual #51 on 7/3/21 at 6:50 p.m., and Individual #38 on 9/6/21 at 7:30 a.m.

a. and c. and d. For Individual #70's restraint on 8/24/21 at 1:19 p.m., and Individual #38's restraint on 9/6/21 at 7:30 a.m., nurses performed physical assessments, and documented whether there were any restraint-related injuries or other negative health effects.

The following provide examples of problems noted:

- Individual #148's restraint on 6/11/21 at 9:26 p.m., and Individual #51's restraint on 7/3/21 at 6:50 p.m. were discovered restraints. In other words, staff did not notify nursing staff during or immediately following the restraints. Once discovered, nursing staff did not conduct vital sign assessments for either individual.
    - For Individual #51, nursing staff did not complete and/or document an assessment for injuries.

      In its comments on the draft report, the State disputed the findings for Individual #51, and referenced assessments conducted on 7/3/21. The assessments to which the State referred were completed in response to staff finding the individual unconscious, and subsequently being sent to the hospital. These assessments are addressed below with regard to Nursing Outcome #1 related to acute illnesses/occurrences. As noted in the draft report, staff did not notify nursing staff on 7/3/21, of the restraint that occurred. It appeared the restraint was not discovered until 7/14/21, through video review. As noted in this and previous reports, an ongoing issue at the Center was staff's failure to notify nursing staff of restraints in a timely manner, which resulted in a lack of restraint-specific assessments.
    - Three days after the restraint, on 6/14/21, at 8:23 a.m., a nurse documented that Individual #148 had "no bruising, redness, abrasions, or overt deformities noted to wrist- where client was restrained."

      In its comments on the draft report, the State questioned the score of 0 for Individual #148 for Indicator c. Conducting an assessment three days after the restraint did not meet the requirements of the Settlement Agreement. A contributing issue was staff not notifying nursing of the restraint when it happened. As explained in the draft report, this is an ongoing issue that requires corrective action. To ensure individuals' safety, Center staff need to work together to ensure that nurses are notified timely and that nurses timely assess individuals following restraints.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	148	70	51	38						
15	Restraint was documented in compliance with Appendix A.	100% 4/4	1/1	1/1	1/1	1/1						
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	148	70	51	38						

16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	25% 1/4	0/1	0/1	1/1	0/1						
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments: 16. For Individual #148 6/11/21, given the errors in documentation, there should have been a recommendation for inservice or monitoring. For Individual #70 8/24/21, the lack of use of Ukeru pads should have been identified as an area for action and follow-up. For Individual #38 9/6/21, the review occurred, but after five days.												

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: There were no usages of crisis intervention chemical restraint during the review period.			Individuals:									
#	Indicator	Overall Score	148	70	51	38						
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	N/A										
48	Multiple medications were not used during chemical restraint.	N/A										
49	Psychiatry follow-up occurred following chemical restraint.	N/A										
Comments:												

Abuse, Neglect, and Incident Management

The Center achieved and maintained substantial compliance with the requirements of section D of the Settlement Agreement and, as a result, was exited from section D of the Settlement Agreement.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59

a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	N/A	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	0% 0/8	N/A	0/1	0/1	N/A	0/1	0/1	0/1	0/2	0/1

Comments: a. Individual #51 and Individual #114 both received total intravenous anesthesia (TIVA)/general anesthesia for dental treatment in a community hospital. Based on the evidence the Center submitted, informed consent was present, an operative note defined procedures and assessments completed, and post-operative vital sign flow sheets showed nursing staff monitored the individual in accordance with applicable nursing guidelines. However, Center indicated that they received no information from the hospital to confirm that nothing-by-mouth status was maintained as needed.

In addition, Center staff indicated that evidence of "medical clearance" to receive TIVA/GA was unavailable. However, as discussed in previous reports, the Center's policy related to perioperative assessment and management needed to be expanded and improved. Dental surgery is considered a low-risk procedure; however, an individual might have co-morbid conditions that potentially put the individual at higher risk. Risks are specific to the individual, the specific procedure, and the type of anesthesia. The outcome of a preoperative assessment should be a statement of the risk level. The evaluation should also address perioperative management, which includes information on perioperative management of the individual's routine medications. A number of well-known organizations provide guidance on completion of perioperative evaluations for non-cardiac surgery. As discussed in previous reports, the Center's policies with regard to criteria for the use of TIVA and general anesthesia, as well as the policies related to perioperative assessment and management, also needed to be expanded and improved. Given the risks involved with TIVA/GA, it is essential that such policies be developed and implemented. Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures.

b. Seven individuals were administered oral pre-treatment sedation for dental treatment. Based on the evidence the Center submitted, for each instance of oral pre-treatment sedation, informed consent was present, and an operative note defined procedures and assessments completed. However, the following describes concerns noted with regard to proper procedures overall:

- For all instances of oral pre-treatment sedation, the dentist/PCP did not obtain the input of an interdisciplinary committee/group to determine medication and dosage range.
- For all instances of oral pre-treatment sedation, the Center did not provide any documentation to show confirmation that nothing-by-mouth status was maintained as needed.
- For Individual #139, Individual #83, and Individual #77, Center staff did not document pre-operative/procedure vital signs, because the individuals refused.
- For Individual #77, on 7/19/21, nursing staff did not document post-procedure vital signs (i.e., blood pressure and heart rate readings) on the Medical/ Dental Restraint Checklist, or whether instability was noted and/or addressed. Nurses noted that the individual refused.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/7	N/A	N/A	0/2	N/A	N/A	N/A	0/2	0/2	0/1

Comments: a. In the six months prior to the review, the following individuals in the physical health review group required the use of pre-treatment sedation for a number of appointments. The Monitoring Team selected the following for review: Individual #51 for an eye appointment on 9/20/21, and an electroencephalogram (EEG) on 9/23/21; Individual #83 for an audiology appointment on 9/9/21, and an audiology appointment on 9/23/21; Individual #77 for a cardiology appointment on 8/30/21, and an audiology appointment on 9/10/21; and Individual #59 for an audiology appointment on 10/5/21.

The problem for each was the lack of documentation to show that the PCP determined the medication and dosage range with input from an interdisciplinary committee/group.

It was positive that for each of these uses of pre-treatment sedation, informed consent was present, and nursing staff completed pre- and post-procedure vital sign assessments in accordance with the applicable nursing guidelines.

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: Rio Grande SC IDTs did not address all of the required content regarding PTS, however, they did develop and implement procedures to address the need for the usage of PTS for all individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/5	0/1	0/1	0/1					0/1	0/1
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 5/5	1/1	1/1	1/1					1/1	1/1
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying	100% 5/5	1/1	1/1	1/1					1/1	1/1

	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.	100% 5/5	1/1	1/1	1/1					1/1	1/1
5	If implemented, progress was monitored.	60% 2/5	0/1	1/1	0/1					0/1	1/1
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	0% 0/2		0/1							0/1

Comments:
The scoring of these indicators was based on a review of Individual #31's 4/28/21 dental exam, Individual #144's 3/31/21 dental exam, Individual #148's 4/28/21 dental exam, Individual #29 9/29/21 dental exam and Individual #97's 10/15/22 dental exam.

1. Available documentation for Individual #31 and Individual #144's dental appointments did not reflect a discussion of PTS usage and effectiveness during the past 12 months, or other supports that could be provided for future appointments. Individual #148's available documentation did not reflect a discussion of PTS usage and effectiveness during the past 12 months, other supports that could be provided for future appointments, or the risk and benefit of the procedure with and without PTS. Available documentation for Individual #29's dental appointments did not reflect other supports that could be provided for future appointments, or the risk and benefit of the procedure with and without PTS. Finally, Individual #97's documentation did not reflect other supports that could be provided for future appointments, the risk and benefit of the procedure with and without PTS.

5. No data were available for Individual #31 or Individual #148. Individual #29's tooth brushing was not implemented after April 2021.

6. There was no evidence of progress, or actions to address the lack of progress, for Individual #144 or Individual #97.

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									
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	N/A									

b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	N/A									
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	N/A									
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	N/A									
e.	Recommendations are followed through to closure.	N/A									
Comments: a. Based on information the Center provided, since the last review, none of the individuals living at the Center died.											

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.										
Summary: N/A			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									
d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Center staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

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 DUEs submitted did not have clear clinical relevance to individuals supported by the Center. In addition, follow-up was not documented for the one DUE that included recommendations. These indicators will remain in active monitoring.		
#	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% 0/1

Comments: a. and b. Center staff submitted the following DUEs:

- A DUE for which the topic was identified as: "Drug Utilization Evaluation of Beers Criteria 2019 for ICF-MR [sic] to assess patients at risk for potentially inappropriate medications." The date and/or timeframe for performing the DUE was not documented. The objective of the DUE was to assess patients at risk for potentially inappropriate medications. The Pharmacy staff identified patients who were 65 years of age and older, and evaluated profiles for medications on the Beers Criteria. Four patients were identified.

  The Pharmacy and Therapeutics Committee Meeting minutes, for a meeting on 6/23/21, which were not approved, signed or dated made a vague reference to a DUE, but did not indicate which DUE required no changes.

  The actual outcome of the DUE was not clear. During interview, the Pharmacy Director stated the primary outcome was that staff became educated on the use of the Beers Criteria. There were no medication changes made for any of the individuals, and no corrective action plans were required.
- A DUE for Clonazepam. According to the DUE, the evaluation was "performed during 1st Qtr Sep, Oct, Nov 2021 using 4th Qtr data Jun, Jul, Aug 2021." The objective was to evaluate the treatment protocol for clonazepam at the Center using the Medication Audit Criteria and Guidelines tools. Eleven individuals were identified.

  It was difficult to determine what the DUE was attempting to evaluate, and thus, difficult to determine its clinical relevance. The Medication Audit Criteria were not clearly outlined. The objective and methodology were repeated. Five tables were presented that addressed dosing, indications, pregnancy testing, and overall compliance.

  Four recommendations were documented:
  1. Indications need to be streamlined. This recommendation had appeared in several previous DUEs.
  2. There was no clear recommendation related to the contraindications. The reviewer discussed looking through digital notes and having a discussion with a case manager.
  3. It was recommended that the medical staff update the default labs "so that it reads perform a pregnancy test."
  4. With regards to dosing, "medical staff dosed accordingly for the most part." There was no recommendation to address those instances in which the dosing was not appropriate.

  During the 9/22/21 P&T meeting, there was no documentation of a discussion of any DUE.

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 33 outcomes and 147 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the time of the last review, 22 of these indicators had sustained high performance scores and moved to the category requiring less oversight. Presently, six additional indicators will be moved to this category, in the areas of psychiatry, behavioral health, PNM, OT/PT, communication, and skill acquisition.

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

Assessments

In the ISPs, for most individuals, assessments were determined and updated, though not all were obtained prior to the ISP meeting.

Psychiatric CPEs were written and complete for all but one individual.

In behavioral health, the Center met criteria for almost all individuals in there being a complete annual behavioral health update and functional assessment. About half of the functional assessments were complete in terms of content.

FSA, PSI, and vocational assessments were not readily available to the IDT at least 10 days prior to the ISP. About three-quarters of these assessments included recommendations for skill acquisition.

In order to assign accurate risk ratings, IDTs need to continue 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 and update the Integrated Risk Rating Forms (IRRFs) within no more than five days.

Since the last review, Medical Department staff made improvements to the timely completion of annual medical assessments. They should continue these efforts. In addition, staff should complete interval medical reviews (IMRs) quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable").

Overall, the quality of the AMAs improved. However, the extent of improvement was often provider-specific. Center staff could make continued progress with concentrated efforts on the remaining areas of focus, including ensuring medical assessments include updated active problem lists, and thorough plans of care for each active medical problem, when appropriate.

As noted above, a number of the individuals did not have up-to-date IMRs. For those that did, PCPs often had not thoroughly addressed the chronic/at-risk conditions selected for review.

There was improvement with regard to the quality of annual dental summaries, and to the provision of dental examinations that were completed no earlier than 90 days prior to individuals' annual ISP meetings. However, due to the impact of COVID-19 restrictions during the previous year, none of the examinations were within 365 days of the individuals' prior exams. The Center also should continue to focus on improving the quality of dental exams.

With regard to nursing assessments:

- For the six individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. Improvement also occurred with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments with only a couple of problems noted.
- It was positive that for the six individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components.
- While continued work is needed, it was positive that in the annual record reviews, for about a third of the selected risk areas, and in the quarterly record reviews, for about half of the selected risk areas, nurses included status updates, including relevant clinical data.
- Work is needed to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions.
- It was positive that in five of seven examples, when individuals experienced exacerbations of their chronic conditions, nurses completed assessments in accordance with current guidelines/standards of practice.

Timely referral occurred for one of the two individuals requiring referral to the Physical and Nutritional Management Team (PNMT). It was positive that for the individual who required a PNMT review, the PNMT completed it timely, and it met the criteria for quality and thoroughly addressed the individual's needs. The other individual required a comprehensive PNMT assessment, which the PNMT completed timely. While it met a number of the criteria for quality, key elements of the assessment did not meet the individual's needs.

Seven of the nine individuals in the review group received timely Occupational and Therapy (OT/PT) assessments that were of the correct type based on their needs. Center staff should ensure the completion of assessments when individuals experience changes of status. The quality of OT/PT assessments continues to be an area on which Center staff should place considerable focus.

None of the five comprehensive communication assessments reviewed met all applicable criteria for a quality assessment. However, it was positive that all five assessments met most criteria. With focus on the assessment of communication needs, and

the inclusion of thorough recommendations for IDT consideration, Center staff could make good progress by the time of the next review.

Individualized Support Plans

In the ISPs, one individual's goals met criteria for all five personal goal areas. All of another individual's health and wellness goals met criteria with indicator 1. Improved performance was seen regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks (i.e., two-thirds of all goals).

Overall, about one-third of ISP personal goals were written in measurable terminology and most ISP health and wellness goals were written in measurable terminology. About 10% of the personal goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal; about three-quarters of the health and wellness goals had a good set of action plans.

Implementation and action were not occurring and as a result progress, for the most part, was not occurring.

Staff were knowledgeable of the individuals they supported with some exceptions, noted in the comments below. Revisions to actions when there was no progress (or implementation) remained in need of improvement.

The psychiatry department was identifying psychiatric indicators for reduction and for increase. The psychiatry clinicians need to define the indicators for increase and ensure that the relationship of all of the indicators to the individual's diagnosis is clearly designated.

Regarding annual psychiatric treatment plans, performance was high. Psychiatric support plans were complete.

In behavioral health, data reliability assessments (IOA and DCT) were being conducted regularly. For about two-thirds of the individuals, the findings were below criteria and action should be taken.

PBSPs were implemented timely and all PBSPs were current. About half of the PBSP were complete, meeting all requirements for content and quality.

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.

Similar to the previous review, Center staff sustained some of their progress with regard to the inclusion of nursing interventions in individuals' IHCPs. Staff are encouraged to continue these efforts with particular focus on including a thorough set of interventions that are measurable.

Seven out of nine PNMPs reviewed met the requirements for quality. Given that during the previous review, the Center's score was 67%, and problems noted during that review as well as this review were minimal, if the Center sustains its progress overall, then, after the next review, the related indicator might move to the category requiring less oversight.

There were few SAPs, though each individual had at least one. Most were not written in measurable terminology and none had reliable data.

ISPs

<table>
<tr><td colspan="2">Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.</td></tr>
<tr><td>Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas, however, one individual's goals met criteria for all five personal goal areas and all of one other individual's health and wellness goals met criteria with indicator 1. Across the six individuals, personal goals met criteria in from three to five areas for a total of 21 goals that met criteria. Improved performance was seen regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks (i.e., two-thirds of all goals).

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. Overall, about one-third of personal goals were written in measurable terminology and most health and wellness goals were written in measurable terminology. Indicator 3 shows that about 10% of the personal goals that met criteria with indicator 1 had a good set of action plans to support achievement of the goal and about three-quarters of the health and wellness goals had a good set of action plans. These three indicators will remain in active monitoring.</td><td>Individuals:</td></tr>
</table>

#	Indicator		Overall Score	31	148	64	29	51	85			
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.	Personal goals	17% 1/6 70% 21/30	3/5	4/5	5/5	3/5	3/5	3/5			
		Health goals	17% 1/6 67% 12/18	1/3	2/3	2/3	2/3	3/3	2/3			
2	The personal goals are measurable.	Personal goals	0% 0/6 38% 8/21 36% 10/28	1/3 1/4	1/4 2/5	2/5 2/5	1/3 1/5	2/3 3/5	1/3 1/4			
		Health goals	67% 4/6 92% 11/12 72% 13/18	1/1 2/3	2/2 2/3	2/2 3/3	1/2 1/3	3/3 3/3	2/2 2/3			
3	ISP action plans support achieving the individual's personal goals.		0% 0/6 10% 2/21 33% 2/6 75% 9/12	1/3 1/1	0/4 1/2	0/5 1/2	0/3 1/2	0/3 3/3	1/3 2/2			

Comments: The Monitoring Team reviewed the ISP process for six individuals at the Rio Grande State Center: Individual #31, Individual #148, Individual #64, Individual #29, Individual #51, Individual #85. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly remotely observed individuals at the Rio Grande SC facility.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 27 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and

based on input from individuals on what was important to them. For this review, 21 goals met this criterion. The personal goals that met criterion were:

- the leisure goal for Individual #148, Individual #64, and Individual #85.
- the relationship goal for Individual #31, Individual #148, Individual #64, and Individual #29.
- the work/day/school goal for Individual #64 and Individual #51.
- the independence goal for all six.
- the living options goal for all six.

Individual-specific comments:

- Individual #29, Individual #31, and Individual #51 had limited opportunities to explore new activities and identify new preferences. Their goals did not offer opportunities to explore new leisure activities.
- Individual #85's relationship goal to call her mother did not offer an opportunity for her to learn new relationship skills. Her goal appeared to be a reminder for staff to regularly call her mother.
- Individual #51's goal to compete in Special Olympics did not identify relationship building skills that he needed or would develop.
- Individual #31 and Individual #85 did not have day programming goals. During observations, they were not meaningfully engaged throughout the day. Their ISPs offered few opportunities for functional training and few opportunities for exposure to new activities.
- Individual #148's goal to work at a pizza restaurant folding pizza boxes was not based on his assessed preferences or skills. Individual #29's work goal did not address his work preferences or skills.

Comments on health and wellness goals:

- Eighteen health/wellness/risk areas were identified across the six individuals. All individuals had at least one personal goal related to health and wellness outcomes, most were individualized, and most were based on assessment recommendations. This was good to see. Twelve of the 18 met criteria. For the six health care goals that did not meet criteria, the goal was not based on assessment results or was not aspirational because they were things that the individual was already doing.
    - Individual #31: dental, gastrointestinal issues, and cardiac issues
        - Individual #31's dental goal was aspirational and based on assessed needs. There was no baseline assessment to determine if his goals to address gastrointestinal and cardiac issues were aspirational/needed.
    - Individual #148: dental, medication side effects, and weight
        - Individual #148's goals for dental and medication side effects met criteria. His goal to address weight was not a personal goal.
    - Individual #64: dental, neurological, and cardiac issues
        - Individual #64's goals for dental and cardiac issues met criteria. His goal for neurological issues was not based on assessed needs. There was no baseline to determine if the goal was developed based on needs.
    - Individual #29: aspiration/respiratory compromise, gastrointestinal issues, and dental
        - Individual #29's goals for dental and gastrointestinal risks met criteria. His goal to address his risk for aspiration was written as a goal for staff.
    - Individual #85: dental, weight, and osteoporosis/falls/fractures

        - Individual #85 had personal goals to address her dental and osteoporosis/falls/fractures risks. She did not have a personal goal to address her risk for weight gain.
    - Individual #51: dental, gastrointestinal, and cardiac issues
        - All three goals met criteria.

While many ISP goals were based on known preferences, opportunities to explore new activities and develop new preferences was significantly limited for all individuals. IDTs need to focus on opportunities to expand exposure to new activities in order to identify a broader range of preferences for individuals.

2. Of the 21 personal goals that met criterion for indicator 1, eight also met criterion for measurability. Two others that did not meet criteria for indicator 1 were measurable. Those that were measurable:

- Recreation/Leisure: none
- Relationship: Individual #51
- Job/School/Day: Individual #148, Individual #64, and Individual #51
- Greater Independence: none
- Living Option: all six

For goals that were not measurable, the goal was not written in observable, measurable terms, did not indicate what the individual was expected to do, or how many times they were expected to complete tasks/activities. Those included:

- Recreation/leisure: all six
- Relationship: Individual #31, Individual #148, Individual #64, Individual #29, and Individual #85
- Job/School/Day: Individual #31, Individual #29, and Individual #85
- Greater Independence: all six

For health and safety goals, 11 of the 12 that met criteria for Indicator 1, also met criteria for being measurable. In total, 13 of 18 health care goals were measurable. These goals were not measurable:

- Individual #31: cardiac
- Individual #148: weight
- Individual #29: aspiration and gastrointestinal
- Individual #85: weight

3. For the 21 goals that met criterion for being personal and individualized, two had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk, incorporate needs included in ancillary plans; offer opportunities to make choices and decisions, where relevant; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals. IDTs were struggling with developing a set of action plans that would provide a clear path to goal achievement. Goals that had action plans that were likely to lead to achievement of the goals were:

- Individual #85's recreation/leisure goal.
- Individual #31's living option goal.

For the 12 health care goals that met criteria for Indicator 1, nine had action plans that supported the goal.

Examples of goals that did not meet criteria:

- For Individual #31's goal to dress himself independently by choosing his preferred clothing every morning, the IDT had one skill acquisition plan to put on his shirt. There were no action plans related to choosing his clothing.

- For Individual #148's relationship goal to meet and socialize with his mother at least two times monthly at the patio in Rio Grande SC, action plans did not include needed supports, address barriers, or provide a timeline for implementation. Action plans included:
  - Have weekly video calls with mother and other family members.
  - Socialize by visiting with mother in person once per quarter at RGSC.
  - Will socialize with at least one peer in the patio during non-rush hours.

- Individual #64's work/day goal to work at Guitar Center was aspirational and based on his preferences. Action plans were unlikely to lead towards achievement of his goal. The IDT did not identify specific work skills that he would need to obtain his preferred job or discuss supports that he may need to obtain a job. Action plans included:
  - Attend greater than 90% of Educational and Training program per quarter.
  - Work in the CWP program to establish a work schedule.

- For Individual #29's goal to Skype with his sister, he had a skill acquisition plan to turn on his tablet. Action plans did not include support for using Skype to talk with his sister.

- Action plans to support Individual #51's work/day goal to work as a part-time assembler for ORC industries, did not address specific skills or supports that he would need to obtain a job at ORC. Action plans included:
  - Will participate in the CWP greater than 90% and learn the basic principles of working such as duties and schedules.
  - Will attend E&T regularly and mii activities that involve assembling for ORC Industries.

- Individual #85 had one action plan related to her living option goal to live in a group home with onsite nursing care in Harlingen, TX that is near a park. She had one related action plan:
  - Continue to explore options that provide more intensive nursing care onsite.

Outcome 2: The individual's ISP set forth a plan to achieve goals.	
Summary: About half of action plans had sufficient detail for implementation and less than half had useful documentation. The number of goals and action plans to which these indicators were applied was relatively small given that some did not meet criteria with indicators 1, 2, and/or 3. These will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	31	148	64	29	51	85			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	50% 1/2 50% 1/2 50% 3/6 67% 6/9	0/1 1/1	-/- 0/1	-/- 0/1	-/- 1/1	-/- 2/3	1/1 2/2			
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	33% 2/6 50% 4/8 0% 0/6 9% 1/11	1/1 1/1	0/1 0/2	1/2 0/2	0/1 0/1	1/2 0/3	1/1 0/2			

Comments:

4. For one of the two goals that had action plans to support the goal, the action plans provided sufficient detailed information for implementation, data collection, and review to occur. For the most part, action plans were simple statements, lacking specific implementation strategies, supports needed, and criteria for documenting and assessing progress. The one goal that included action plans that met criteria were action plans to support Individual #85's recreation/leisure goal.

Six of the nine health care goals that had action plans to support the goals provided detailed information for implementation, data collection and review to occur.

The QIDP department had identified the need to improve the quality of action plans to support achievement of goals.

5. Of the eight goals that met criteria with indicators 1 and 2, four had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. These were:

- QIDP monthly reviews documented the status of living option goals for Individual #31, Individual #64, Individual #51, and Individual #85.

Of the 11 health and wellness goals that were individualized and measurable, one (Individual #64's dental goal) had documentation that was reliable to determine if the individual was making progress or had met the goal.

QIDPs were completing monthly reviews and commenting on each action plan. For the most part, comments typically noted that documentation was not available to review. When available, data were included in comments, however, QIDPs were not summarizing progress/lack of progress towards goals.

Individual #29's ISP meeting was observed. The IDT was unable to determine what specific progress had been made towards goals over the past year. Decisions to continue or discontinue goals were not based on data available to the team but relied on anecdotal reports from various IDT members on whether he had made progress, needed more training, or was no longer interested in the activity.

Outcome 3: All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.

Summary: Implementation and action were not occurring and as a result progress, for the most part, was not occurring. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	148	64	29	51	85			
6	The individual met, or is making progress towards achieving, his/her overall personal goals.	25% 1/4 25% 1/4	0/1	-/-	1/1	-/-	0/1	0/1			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/3 0% 0/3	0/1	-/-		-/-	0/1	0/1			

Comments:

6. For all individuals, QIDP monthly reviews documented that action plans had not been consistently implemented, thus, individuals had not made progress towards their goals apart from Individual #64. He was making progress toward his living option goal and dental goal.

7. None of the individuals had met an ISP goal.

8. QIDPs were reviewing action plans monthly, which was good to see. IDTs met often and documented discussion regarding the lack of implementation and progress. Revisions were made to plans, however, there was little evidence that revisions were implemented timely. A review of ISP preparation documents and recent data indicated that action plans were rarely implemented at the recommended frequency and barriers to implementation were not addressed.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.												
Summary: For most individuals, assessments were determined and updated; though not all were obtained prior to the ISP meeting. Overall, ISPs were not implemented timely. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	31	148	64	29	51	85				
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
	b. 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				
10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	33% 2/6	0/1	0/1	0/1	0/1	1/1	1/1				
11	a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1				
	b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1				
	c. Assessments were updated as needed in response to significant changes.	100% 4/4			1/1	1/1	1/1	1/1				

Comments:

9b. The ISP was not implemented within 30 days of the meeting for any of the individuals. For all individuals, multiple action plans had not been implemented. Examples included:

- For Individual #31, action plans were not implemented included:
  - E&T will present with 3-4 activity pictures.
  - Will have a picture of his family in his room.
  - QIDP to call mother to identify what app she uses to video call.
  - Assess to see what his interest and skills are.
- For Individual #148, the following action plans were not implementation within 30 days of his ISP development:
  - Have weekly video calls with his mother.
  - Attend E&T classes 70% per month.
  - SLP to provide picture for activities for service objective
  - IDT to meet to discuss SAP prioritizations
- For Individual #64, the following action plans were not implemented within 30 days of ISP development:
  - Will attend greater than 90% of E&T program per quarter.
  - Will participate with all music activities at the facility and invite a peer to join him.
  - Will spend time with a friend once a week to have a preferred meal while listening to music.

    - Will participate in the music room playing guitar.
- For Individual #29, action plans not implemented within 30 days of ISP development included:
    - IDT to meet to implement action plans to help Individual #29 reach his work goal
    - Skill acquisition plan to turn on radio.
    - Skill acquisition plan for hand washing.
- For Individual #51, action had not been implemented within 30 days of ISP development, including:
    - Participate in E&T music room.
    - Will engage in basketball games in the facility at least 3-4 times weekly to prepare for Special Olympics.
    - Will pick out a picture of his favorite sport or sports player or a family picture to place in his room.
    - Will buy decorations to be used in his room per his preference.
- For Individual #85, action plans not implemented within 30 days of ISP development included:
    - Skill acquisition plan for using cause and effect hand manipulatives.
    - Skill acquisition plan to turn on/off a radio.

10. Two of the six individuals had appropriately constituted IDTs, based on their strengths, needs and preferences, who participated in the planning process. Findings included:

- Individual #31, Individual #148, Individual #64, and Individual #29 did not attend their ISP meetings. There was no documentation of meaningful participation in the planning process. For Individual #29, his ISP did not indicate that he was actively involved in development of his ISP. The IDT might consider pairing his meeting with other activities that he enjoys or restructuring the meeting to be more meaningful to him.
- For Individual #31, Individual #148, and Individual #29, there was not documentation of attendance or input by their LAR or AIP.
- For Individual #64, Admissions Placement Staff did not attend his meeting. He had been referred for community placement. The IDT failed to develop specific action plans related to his referral.

QIDPs recognized that attendance was poor by individuals at ISP meetings. According to their own review data, individual attendance for the last quarter was 24%. The department planned to continue to monitor ISP attendance and had implemented strategies to improve individual attendance.

Four of six individuals did not attend their ISP meetings. For three of six, the LAR/family did not attend. For the most part, the ISPs contained broad statements that individuals were invited/prompted/encouraged to attend and that LARs/family members were mailed letters with the date and time and option to request an alternate date.

Given that individual/LAR attendance is a core part of person-centered planning, the Center should focus on ways to increase individual and family participation. Examples include offering a range of dates/times for meetings, including times that do not interfere with work and other daily activities, breaking the meeting up into smaller sessions with one session focused on input from the individual/family on goals and activities, holding meetings in locations that the individual enjoys (i.e., park, coffee shop, library).

Overall, ISPs at the Center are typically lengthy and IDTs rarely encourage active participation by the individual. An individual's ISP should be focused on that person and any input that they want to offer to the team. This may mean that the IDT needs to provide communication, behavioral, and/or other supports, when needed. ISP meetings should be meaningful to the individual and support them to feel empowered. Teaching and supporting self-advocacy should be part of the team process and addressed in the ISP when it is a barrier to participation.

11a. For five individuals, the IDT considered what assessments the individual needed and would be relevant to the developments of the ISP prior to the annual meeting. Individual #31's IDT did not document discussion of assessments needed during his ISP Preparation meeting.

11b. One of the IDTs (Individual #31) arranged for and obtained the needed, relevant assessments prior to the IDT meeting.

- Individual #148's annual medical assessment was not submitted at least 10 days prior to his annual ISP meeting for IDT consideration.
- Individual #64's functional skills assessment and annual medical assessment were submitted late.
- Individual #29's day assessment was not timely.
- Individual #51's day and annual medical assessment were not submitted at least 10 days prior to his annual ISP meeting.
- Individual #85' s day and annual medical assessment were not submitted at least 10 days prior to her annual ISP meeting.

11c. For four of four individuals with a status change during the year, assessments were updated as needed in response to changes. This included Individual #64, Individual #29, Individual #51, and Individual #85.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: For all but one of the individuals, there was a thorough examination of living options. More work was then needed on plans. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	148	64	29	51	85			
12	There was a thorough examination of living options.	83% 5/6	1/1	0/1	1/1	1/1	1/1	1/1			
13	a. 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			
	b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	50% 3/6	0/1	1/1	1/1	0/1	1/1	0/1			
14	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			

15	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			

Comments:

12. For five individuals, there was a thorough examination of living options.
    - For Individual #148, his IDT acknowledged that his family would like him to move to the community and that Individual #148 would like to live with his family. They did not discuss specific options that might provide the supports that he needs to be able to live closer to/with his family in the community.

13a. None of the ISPs had action plans that were likely to lead towards community integration in a meaningful way. Some ISPs had goals to live and work in the community and broadly stated action plans to visit in the community, however, there were no action plans to support integration. All supports, services, and training were being provided at the facility.

Individual #51 had a goal to participate in Special Olympics in the community, and there were two broadly stated related action plans. One was to engage in basketball games at the facility to prepare for Special Olympics and the other was to participate in Special Olympics in the community. This was a great first step, however, without identifying needed training, identifying barriers and supports needed, it was unlikely that he would achieve his goal. Further, both action steps were carried over from the previous ISP year. His action step to play basketball on campus three to four times each week was never fully implemented and barriers were not addressed. His action plan to participate in Special Olympics was on hold due to Covid-19. On the positive, the IDT made recommendations to address barriers and teach necessary skills (e.g., learn the formal rules of basketball, practice inviting a peer to play, ensure that he has needed equipment), but none were addressed through action plans.

13b. Three IDTs (Individual #148, Individual #64, Individual #51) considered opportunities for day programming in the most integrated setting consistent with preferences and support needs. Day programming was not well defined for the other three individuals. Day and work opportunities were limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

14. None of the ISP action plans included individualized measurable plans to educate the individual/ LAR about community living options. Individuals had broadly stated action plans to provide information to the individual and LAR annually, attend provider fairs, and/or attend a community tour. Action plans were implemented year after year with little revision and little impact on the individual's understanding of living options. For example,

- Individual #148 did not have action plans to educate him or his LAR about community living options.
- Individual #29's action plans to support his goal to reside in a group home in Harlingen, TX were:
    - Annually reach out to LAR and inform of community living options
    - Invite to provider fairs.
- Individual #85 had one action plan to support her goal to live in the community:
    - Continue to explore options that provide more intensive nursing car on-site.
- Individual #51's action plans to educate his LAR on living options included:
    - Educate LAR regarding community living options annually.

- Invite LAR to provider fairs.

15. IDTs had not created individualized, measurable action plans to address identified obstacles to referral. Action plans were broadly stated with little detail for implementation. Few addressed actual barriers to living in a less restrictive setting.

- Individual #31's action plans were more individualized to address barriers, however, they were not measurable action plans.
- Individual #64 had one action plan for the IDT to meet in 14 days to discuss the referral process. The IDT met but did not develop measurable goals for referral.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.

Summary: Staff were knowledgeable of the individuals they supported with some exceptions, noted in the comments below. ISP action plan implementation and revisions to actions when there was no progress remained in need of improvement. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	148	64	29	51	85			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	67% 4/6	1/1	0/1	1/1	0/1	1/1	1/1			
17	Action plans in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	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:

16. For four individuals, staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. Staff were attentive and respectful to individuals during observations.

- Individual #148 was in bed during all observations. None of his action plans had been consistently implemented. At an ISPA meeting that was observed, IDT members were not familiar with his goals and action plans and unable to determine the status of goals.
- Individual #29's ISP meeting was observed. Staff were unable to discuss specific supports that he needed or the status of action plans implemented over the past year.

17. For all individuals, action plans had not been implemented and individuals had not made progress towards most goals. There was a total of 66 action steps evaluated. Seven (11%) were on hold either due to COVID-19 community gathering restrictions or behavioral/health concerns that impacted individual's ability to participate in implementation. For the 59 action plans that could be implemented, 15 (25%) had been consistently implemented.

Individual	# of Action Steps in ISP	Action Steps Implemented	Action Steps On Hold	Action Steps Not Fully Implemented
Individual #31	13	1	0	12
Individual #64	15	3	2	10
Individual #148	13	5	0	10
Individual #29	6	1	2	3
Individual #51	15	4	3	8
Individual #85	4	1	0	3

18. QIDPs did not ensure the individual received required monitoring/review and revision of treatments, services, and supports. QIDPs were reviewing all services and supports monthly, however, they were rarely summarizing specific progress towards goals. In most cases, they were documenting when an action plan was implemented, but not commenting on the individual's response to training or noting specific supports needed. Barriers had not been addressed when services and supports were either not implemented or not effective or when the individual failed to make progress towards goals. Examples of action plans that were not implemented and barriers to implementation were not addressed included:

- For Individual #64, action plans to operate a CD player, participate in music activities at the facility with a peer, spend time with a friend having a preferred meal while listening to music, and purchasing a CD of his choice in the community had not been implemented.
- For Individual #31, action plans to participate in outdoor activities with a peer and have a picture of his family in his room were not implemented.
- For Individual #148, action plans to video call his mother weekly, learn how to brush his teeth, and socialize with at least one peer on the patio were not implemented.
- For Individual #29, his SAP for handwashing was never developed.
- For Individual #51, his SAPs for brushing his teeth and locking his brakes on his wheelchair were never developed. He had not bought decorations to be used in his room. Individual #51's QIDP monthly reviews documented monthly reminders to the SAP writers for at least eight months regarding lack of implementation, however, SAPs were never developed, and no other action was taken by the IDT to implement training or address barriers to training.

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 and update the IRRFs within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	The individual's risk rating is accurate.	17%	0/2	0/2	1/2	0/2	N/R	0/2	N/R	1/2	N/R

		2/12									
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.	42% 5/12	2/2	1/2	0/2	0/2		0/2		2/2	

Comments: For six individuals, the Monitoring Team reviewed a total of 12 IRRFs addressing specific risk areas [i.e., Individual #64 – constipation/bowel obstruction, and circulatory; Individual #31 – constipation/bowel obstruction, and fractures; Individual #51 – seizures, and falls; Individual #85 – gastrointestinal (GI) problems, and infections; Individual #114 – cardiac disease, and respiratory compromise; and Individual #77 – diabetes, and respiratory compromise].

a. The IDTs that effectively used supporting clinical data, used the risk guidelines when determining a risk level, and as appropriate, provided clinical justification for exceptions to the guidelines were those for Individual #51 – falls, and Individual #77 – respiratory compromise.

b. For the individuals in the review group, it was positive that the IDTs updated the IRRFs at least annually.

However, often when changes of status occurred that necessitated at least review of the risk ratings, IDTs did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #64 – constipation/bowel obstruction, and circulatory; Individual #31 – constipation/bowel obstruction; and Individual #77 – diabetes, and respiratory compromise.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: At Rio Grande SC, there was progress in the sub-indicators of some of the indicators in this outcome. The psychiatry department was identifying indicators for reduction and for increase. The psychiatry clinicians need to define the indicators for increase and ensure that the relationship of all of the indicators to the individual's diagnosis is clearly designated. The psychiatry clinic was developing goals and generally entering these into the facility's overall treatment program, the IHCP. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/8	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% 0/8	1/2	1/2	1/2	1/2	1/2	1/2	1/2		1/2
6	Psychiatry goals are documented correctly.	38%	0/2	0/2	1/2	2/2	1/2	2/2	2/2		0/2

		3/8									
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	1/2	1/2	1/2	1/2	1/2	1/2	1/2		1/2

Comments:
The scoring in the above boxes has 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. Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

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 an individual's 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.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder and normed for this population.

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 as all individuals in the review group had at least one psychiatric indicator related to the reduction of psychiatric symptoms and all individuals had an indicator for increase identified. The indicators were documented in the psychiatry goals grid included in the annual psychiatry report or in the psychiatric quarterly. The relationship of the indicator for decrease to the individual's specific diagnosis was not individualized and in most cases was determined intuitively (e.g., psychosis related to a diagnosis of schizophrenia). The use of intuitive deduction will not always be possible, and although generally scored affirmatively during this review, the indicators for reduction will need to be clearly related to the individual's diagnoses. The identified indicators for increase were typically either education and training attendance or outing participation. There was no individualized documentation regarding the relationships of these indicators to the individual's specific diagnoses.

Once an indicator is identified and related to a specific diagnosis, the next step is to define the indicator such that staff recording the presence of a specific indicator will be able to correctly identify the indicator. When indicators are the same as a behavioral health target behavior, behavioral health generally defines the indicator. When indicators are different from behavioral health target

behaviors, psychiatry needs to specifically define the indicator. The indicators for decrease included specific, individualized definitions with the exception of the impulse indicator for reduction identified for Individual #148. All individuals had a specific psychiatric rating scale/subscale identified as the measure of their indicator for decrease. For the indicators for increase, there was no specific definition of education and training attendance or outing participation. This is a challenge with regard to indicators requiring attendance because it is not clear if an individual has to simply present to a particular activity or participate in some way for a specified period of time.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for all individuals in the review group with the exception of Individual #148. Criteria for psychiatric indicators for increase were not met for any of the individuals in the review group.

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.

The psychiatric goals regarding the indicators for increase and decrease were included in the psychiatric documentation for (e.g., the CPE and quarterly psychiatric). This was good to see.

The second part of this indicator requires the designation of data collection methods. This would include how and when data are collected. The psychiatry goals grid noted that for the indicators for decrease, all data would be via a specified subscale of the DASH II completed on a quarterly basis. While the grid did not indicate who was responsible for the completion of the DASH II, this facility has an unwritten procedure that assessment instruments are provided to behavioral health staff who, via collaboration with direct care staff, complete the assessment instruments and return them to psychiatry clinic staff for inclusion into the psychiatric clinical documentation. With regard to the indicators for increase, there was a notation in the goals grid for some individuals that data would be derived from information from staff and by also reviewing the data of attendance at outings. There was no notation of the frequency of review of these data, trending of these data, or reliability of these data.

As the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals and the collection of data utilizing rating scales normed for this population could be considered.

Thus, both sub-indicators were met for all of the individuals in the review group for goals for reduction and for no individuals for a goal for increase.

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, goals for reduction and increase were generally included in the IHCP for those individuals who had an ISP meeting after April 2021. Thus, there were goals for reduction and increase included in the IHCP documents for Individual #17, Individual #70, and Individual #43.

7. Data:
Reliable and valid data need to be available so that the psychiatrist/psychiatric nurse practitioner can use these data to make treatment decisions. Data are typically presented in graphic or tabular format for the clinician. Data need to be shown to be reliable.

At Rio Grande SC, data regarding indicators for decrease were presented as table of DASH II subscale results gathered on a monthly basis. While these data were not tabulated or trended, they were presented in a series of three months of results and could be compared over a 90-day period of time. These data, gathered via specific rating scales, have intrinsic reliability and validity based on the scale itself. As rating scales were utilized for reporting indicators for reduction for all individuals in the review group receiving psychiatric services, these data were reliable.

With regard to data for the indicators for increase, these were not included in the psychiatry clinical documentation. There were notations that an individual was meeting or not meeting a goal related to education and training attendance or outing participation, but there were no trended data regarding these indicators and there was no determination of the reliability of these reported data.

Thus, all eight individuals participating in psychiatry clinic had reliable data presented regarding the indicators for reduction, and no individuals had reliable data presented regarding the indicators for increase.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.											
Summary: CPEs were written and complete (for all but one individual). With sustained high performance, indicators 14 and 15 might be moved to the category of requiring less oversight after the next review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1		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	100% 1/1							1/1		

	completed within the first business day, and a CPE was completed within 30 days of admission.											
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.	63% 5/8	1/1	0/1	1/1	1/1	1/1	0/1	0/1		1/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. Seven of the CPEs included all of the required components. The remaining CPE, regarding Individual #43, was missing an adequate social history and bio-psycho-social formulation. Overall, this individual's sexuality/gender identity issues were not adequately addressed.

15. There was one individual admitted in the two years prior to the review, Individual #43. There was a CPE completed within 30 days of admission and an admission IPN from nursing and primary care documented by the next business day after admission.

16. There were three individuals whose records revealed inconsistent diagnoses, Individual #144, Individual #70, and Individual #43.
    - For Individual #144, the AMA included a diagnosis of Intermittent Explosive Disorder, that was not part of the psychiatric diagnoses.
    - For Individual #70, the AMA did not include diagnoses of Conduct Disorder, THC use disorder, or Tobacco use disorder.
    - For Individual #43, the AMA reported the diagnosis of Intermittent Explosive Disorder as history of, while psychiatry has this as an active diagnosis.

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

Summary: Performance was high across this set of indicators. Indicator 17 showed sustained high performance and will be moved to the category of requiring less oversight. With sustained high performance, the other indicators might also be moved to this category after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
17	Status and treatment document was updated within past 12 months.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1			1/1
18	Documentation prepared by psychiatry for the annual ISP was complete (i.e., annual psychiatric treatment plan).	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1			1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	86% 6/7	1/1	0/1	1/1	1/1	1/1	1/1	1/1		
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	88% 7/8	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.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1

Comments:

17. Seven individuals required annual evaluations. All were completed.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. All of the annual evaluations contained all of the required elements.

19. Six of the eight individuals requiring an initial or annual CPE had one completed prior to the initial or annual ISP meeting. For Individual #144, the annual psychiatric evaluation was dated 10/16/20 with an ISP date of 12/10/20. Per the QIDP data, the document was due 11/26/20 and was not submitted until 1/6/21. Individual #97 was not scored for this item because his annual evaluation was performed in October 2021, so the data for this year's ISP were not yet available.

20. The psychiatric nurse practitioner attended the ISP meeting for seven individuals in the review group. The nurse practitioner did not attend the ISP meeting regarding Individual #64 because she was on vacation. The psychiatric assistant was in attendance and presented information.

Overall, the level of attendance at the meetings was good to see.

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. In all examples there was comprehensive information presented regarding the required elements. This was good to see.

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

Summary: PSPs were complete. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	100% 2/2									

Comments:

22. The PSP documents regarding Individual #108 and Individual #12 were reviewed. The PSPs include all the required elements. While the documents did not consistently note who was responsible for completing the rating scales to assess symptoms, this facility had an unwritten procedure that behavioral health completed the assessments and returned them to psychiatry for data reporting and inclusion into the psychiatric clinical documentation.

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

Summary: Improvements sustained since the last review and with continued high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, these indicators were 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.										
30	A risk versus benefit discussion is in the consent documentation.	88% 7/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	100% 8/8	0/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
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:

30. A sufficient risk versus benefit discussion was included in the consent forms in seven examples. There was a need for improvement in the risk versus benefit discussion regarding Individual #31 given the complexity of his prescribed regimen via the prescription of Tegretol, which is used for seizure, but impacts the other prescribed medications necessitating the need to address cumulative risk.

31. The consent forms for all individuals in the review group included alternate, non-pharmacological interventions in addition to the PBSP or PSP.

Psychology/behavioral health

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

Summary: IOA and DCT assessments were being conducted regularly, which was good to see. For about two-thirds of the individuals, the findings were below criteria and action should be taken. Also, indicator 4 will remain in the category of

Individuals:

requiring less oversight, however, criteria were not met for two individuals as noted in the comments below. Indicator 5 will remain in active monitoring.											
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.										
3	The psychological/behavioral goals/objectives are measurable.										
4	The goals/objectives were based upon the individual's assessments.										
5	Reliable and valid data are available that report/summarize the individual's status and progress.	29% 2/7	0/1	0/1	1/1	0/1	1/1	0/1			0/1

Comments:

4. Individual #17 has unauthorized departure as a target behavior however, his BHA indicated that he did not engage in this behavior. Individual #31's progress note has an objective to reduce urination and defecation outside, however, this target behavior was not included in his most recent functional assessment.

5. Individual #148 and Individual #64 had evidence of data collection timeliness (DCT) and interobserver agreement (IOA) assessments that averaged 80% or above during the last six months.

Individual #43's PBSP data reliability was not scored because she had not engaged in any target behaviors at the time the data were reviewed.

The average of Individual #31, Individual #144, Individual #17, Individual #70, and Individual #97's DCT assessments in the last six months was below 80%, and the average of Individual #70's IOA in the last six months was below 80%.

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. If the levels of IOA or DCT are found to be below 80%, the DSP should be retrained and reassessed as soon as possible. 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: Performance was about the same as at the last review. With sustained high performance, indicators 10 and 11 might be moved to the category of requiring less oversight after the next review. Functional assessment activities needed improvement as detailed in the comments below for indicator 12. All three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
12	The functional assessment is complete.	43% 3/7	0/1	1/1	1/1	0/1	0/1	0/1	0/1		1/1

Comments:

10. Individual #148's BHA did not include an intellectual assessment.

12. Individual #31's functional assessment was judged to be incomplete because the indirect assessment (MAS) was determined to be inconsistent and not useful, and no target behaviors were observed during the direct observations. Since there were no data regarding the target behaviors from the indirect and direct assessments, it was not clear how his antecedents and consequences were identified in the conclusion of the functional assessment.

Individual #17's indirect assessment (MAS) was also determined to be uninterpretable, and he and Individual #70's stated consequences were not hypothesized consequences of his target behaviors, but rather a statement of planned consequences of his target behaviors.

Individual #64's indirect assessment (MAS) was also determined to be uninterpretable, however, apparently staff were also interviewed. This interview suggested that negative reinforcement may be the consequence of some of Individual #64's aggression and that a possible antecedent was taunting by peers. His functional assessment, however, concluded that there were no antecedents or consequences related to his target behaviors and concluded that the function was automatic.

All of the functional assessments utilized the Motivation Assessment Scale (MAS) for the indirect functional assessment. Most of those functional assessments also concluded that the information from the MAS was uninterpretable. Additionally, several (e.g., Individual #31's functional assessment) did not attempt to use another behavior rating scale (e.g., FAST, QABF, etc.), or a structured (e.g., Functional Assessment Interview), or an open-ended behavioral interview. Indirect assessments are a critical component of an effective functional assessment. If one does not yield useful results, it is necessary to try another indirect assessment.

Similarly direct assessments (i.e., direct observation of the target behaviors) are also critical to the effective identification of antecedent and consequences of target behaviors. As noted above, several functional assessments included direct assessments that did not include observation of target behaviors. Direct observation that do not help to identify antecedent and consequences of target behaviors are minimally useful for developing effective functional assessments. Ensuring that indirect and direct assessments logically lead the reader to the hypothesized antecedents and consequences of all target behaviors should be a priority for Rio Grande SC.

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

Summary: PBSPs were implemented timely and all PBSPs were current. The latter has been the case for three consecutive reviews and, therefore, indicator 14 will be moved to the category of requiring less oversight. With sustained high performance, the same might occur for indicator 13 after the next review. Performance on indicator 15 maintained. Indicators 13 and 15 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
14	The PBSP was current (within the past 12 months).	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
15	The PBSP was complete, meeting all requirements for content and quality.	71% 5/7	1/1	1/1	1/1	0/1	1/1	0/1			1/1

Comments:

13. All PBSPs had documentation that they were implemented within 14 days of receiving necessary consents. This represents an improvement over the last review when 63% of PBSPs had the necessary consents.

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

Neither Individual #17's nor Individual #70's PBSP specifically included the reinforcement of desired behaviors.

Additionally, Individual #70's PBSP suggested interventions based on a function (i.e., negative reinforcement) not identified in his functional assessment or PBSP as a possible consequence of his target behaviors. Individual #70's PBSP also identified functions of his target behaviors (i.e., sensory, attention) that were not addressed by the PBSP interventions.

Individual #17's PBSP included interventions based on a sensory function of his target behaviors that was not identified in his functional assessment. Additionally, Individual #17's replacement behavior was not functional, (or did not include an explanation of why a functional replacement behavior was not used). Finally, Individual #17's PBSP contained target behaviors (i.e., taunting, disruption, unauthorized departure) that were not reviewed in his functional assessment.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary:			Individuals:									
#	Indicator	Overall Score										
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.											
Comments:												

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Since the last review, when Indicator b was at risk of returning to active oversight, Medical Department staff made improvements to the timely completion of annual medical assessments. They should continue these efforts. In addition, staff should complete interval medical reviews quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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, these indicators 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.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	25% 2/8	0/1	0/1	1/1	0/1	0/1	0/1	N/A	0/1	1/1
Comments: b. All nine individuals in the review group had current AMAs (i.e., no older than 365 days), including one individual who was newly-admitted. Clearly, since the last review, Medical Department staff worked to catch up on the overdue assessments. However, due to previous problems, four of the AMAs were not completed within 365 days of the previous ones. For three individuals (i.e., Individual #64, Individual #31, and Individual #114), the previous AMAs were completed in 2019.											

Due to similar problems at the time of the last review, the Monitor indicated that Indicator b was at risk of returning to active oversight. Given that it appeared Center staff had taken steps to correct the problem and all nine individuals had AMAs completed within the last 365 days, Indicator b will continue in less oversight. Center staff should continue their efforts to keep AMAs up-to-date.

c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). Two of the eight applicable individuals had timely IMRs.

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

Summary: Overall, the quality of the AMAs improved. However, the extent of improvement was often provider-specific. Center staff could make continued progress with concentrated efforts on the remaining areas of focus, including ensuring medical assessments include updated active problem lists, and thorough plans of care for each active medical problem, when appropriate.

As noted above, a number of the individuals did not have up-to-date IMRs. For those that did, PCPs often had not thoroughly addressed the chronic/at-risk conditions selected for review. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	Individual receives quality AMA.	33% 3/9	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1	1/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	6% 1/16	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1

Comments: a. It was positive that three individuals' AMAs (i.e., Individual #31, Individual #139, and Individual #59) included all of the necessary components, and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Problems varied across the remaining AMAs the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all AMAs addressed pre-natal histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Most, but not all included, as applicable, family history, social/smoking histories, and childhood illnesses. Moving forward, the Medical Department should focus on ensuring medical assessments include updated active problem lists, and thorough plans of care for each active medical problem, when appropriate.

Most of the annual medical assessments met many of the criteria for quality. With concentrated efforts on the remaining areas of focus, PCPs could make good progress on this indicator.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [i.e., Individual #64 – GI problems, and hypothyroidism; Individual #31 – macrocytic anemia, and constipation/bowel obstruction; Individual #51 – history of colon polyps, and seizures; Individual #85 – constipation/bowel obstruction, and B12 deficiency; Individual #139 – SNHL, and Vitamin D deficiency; Individual #114 – GI problems, and cardiac disease; Individual #83 – Vitamin D deficiency, and unspecified anemia; Individual #77 – adrenal insufficiency, and osteoporosis; and Individual #59 – hypertension, and osteoporosis].

As noted above, a number of the individuals did not have up-to-date IMRs. For those that did, PCPs often had not thoroughly addressed the chronic/at-risk conditions selected for review. The IMR that followed the State Office template, and provided necessary updates related to the risk was for: Individual #51 – seizures.

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

Summary: As indicated in the last several reports, overall, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #64 – GI problems, and hypothyroidism; Individual #31 – macrocytic anemia, and constipation/bowel obstruction; Individual #51 – history of colon polyps, and seizures; Individual #85 – constipation/bowel obstruction, and B12 deficiency; Individual #139 –SNHL, and Vitamin D deficiency; Individual #114 – GI problems, and cardiac disease; Individual #83 – Vitamin D deficiency, and unspecified anemia; Individual #77 – adrenal insufficiency, and osteoporosis; and Individual #59 – hypertension, and osteoporosis).

For the 18 chronic diagnoses and/or at-risk conditions, IHCPs either did not exist or did not include action steps to sufficiently address them in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.

b. As noted above, per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are

limited to "very select individuals who are medically stable"). As a result, IHCPs no longer need to define the parameters for interval reviews, so the Monitoring Team did not rate this indicator.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: There was improvement with regard to the quality of annual dental summaries, and to the provision of dental examinations that were completed no earlier than 90 days prior to individuals' annual ISP meetings. However, due to the impact of COVID-19 restrictions during the previous year, none of the examinations were within 365 days of the individuals' prior exams. The Center should also continue to focus on improving the quality of dental exams.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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	0/1	N/A	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.	0% 0/1 Cannot fully rate due to COVID-19	N/R-C	N/R-C	N/R-C	N/R-C	0/1	N/R-C	N/A	N/R-C	N/R-C
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	88% 7/8	1/1	1/1	1/1	1/1	0/1	1/1	N/A	1/1	1/1
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual receives a comprehensive dental summary.	67% 6/9	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1
Comments: a. The following describes concerns noted: • For the one newly-admitted individual, Center staff did not complete a dental examination within 30 days. Individual #83 was admitted on 8/2/21. Dental Department staff unsuccessfully attempted to complete a dental examination on three occasions within the first 30 days. On 9/8/21, the dentist was somewhat successful in completing a partial exam. The dentist completed											

the dental summary on 8/25/21, which was timely for his ISP meeting on 9/1/21; however, it was not based on a current dental examination, so it was not useful to the IDT for planning purposes.

- At the time of the previous review, due to COVID-19 precautions, most individuals reviewed had not received timely annual dental examinations and/or annual dental summaries. Based on interviews at that time with Dental Department staff, the Center did not have a dentist on staff and relied on community resources for completion of dental examinations and summaries. While this remained the case for this review, it was positive that seven of eight applicable individuals received a dental examination within the last year and that those also occurred no earlier than 90 days prior to individuals' annual ISP meeting dates. However, due to the COVID-19 impact (i.e., the lack of dental examinations during 2020), none of the seven examinations were within 365 days of the individuals' previous exams.
- For Individual #139, the Dental Department last completed an annual dental examination on 12/11/19. Documentation indicated Dental Department staff last attempted an examination on 6/23/21, but the individual refused at that time. While his annual dental summary was completed on 6/29/21, it was not based on a current examination, so it was not useful to the IDT for planning purposes.

b. As described above, the Center did not provide a current comprehensive exam for Individual #139. Individual #77's exam met all of the criteria for quality. For the remaining comprehensive examinations, it was positive that all met criteria for the following components of a quality examination:

- A description of the individual's cooperation;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Number of teeth present/missing;
- Treatment provided/completed; and,
- An odontogram.

In addition, most of the examinations included the following components:

- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type; and,
- Sedation use.

The Center should focus most on the following components:

- The recall frequency;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- A treatment plan; and,
- Periodontal charting, updated within the last year, or a justification for not completing it with a plan to complete it.

c. As describe above, for Individual #83 and Individual #139 , the Center did not provide annual dental summaries that were based on current dental examinations. It was positive, though, that the seven remaining dental summaries included all of the following required components:

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

All but one of the seven dental summaries also included a description of a treatment plan that was consistent with the individual's needs, including the recall frequency. The exception was for Individual #51.

Nursing

Outcome 3 – Individuals have timely nursing assessments to inform care planning.

Summary: For the six individuals reviewed, nurses completed timely annual nursing reviews and physical assessments. If Center staff sustain their performance in this area, then after the next review, Indicator a.ii might move to the category requiring less oversight. Improvement was noted with regard to nurses' timely completion of quarterly nursing record reviews and/or physical assessments with only a couple of problems noted.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A	N/A	N/A	N/A	N/A	N/R	N/A	N/R	N/A	N/R
	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.	100% 6/6	1/1	1/1	1/1	1/1		1/1		1/1	
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	67% 4/6	0/1	1/1	1/1	1/1		1/1		0/1	

Comments: a.i. and a.ii. All six individuals in the nursing review group had timely annual comprehensive nursing reviews and physical assessments.

a.iii. With regard to quarterly nursing record reviews and physical assessments, Center staff used the ISP as the anchor date for calculating due dates for quarterly reviews and assessments. Examples of problems included:

- On 6/17/21, Individual #64's IDT held his annual ISP meeting. A quarterly review was due in September. It was not until 10/21/21, that the RNCM completed a quarterly physical assessment and record review.
- For Individual #77, on 3/19/21, the RNCM completed a quarterly nursing record review. The corresponding physical assessment was not dated.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.

Summary: It was positive that for the six individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components. If the Center sustains its progress, then after the next review, Indicator b might move to the category requiring less oversight.

While continued work is needed, it was positive that in the annual record reviews, for about a third of the selected risk areas, and in the quarterly record reviews, for about half of the selected risk areas, nurses included status updates, including relevant clinical data. Work is needed as well to ensure that nurses complete thorough record reviews on an annual and quarterly basis, including analysis related to individuals' at-risk conditions.

It was positive that in five of seven examples, when individuals experienced exacerbations of their chronic conditions, nurses completed assessments in accordance with current standards of practice. Currently, all of these indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	Individual receives a quality annual nursing record review.	0% 0/6	0/1	0/1	0/1	0/1	N/R	0/1	N/R	0/1	N/R
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and	100% 6/6	1/1	1/1	1/1	1/1		1/1		1/1	

	vii. Follow-up for abnormal physical findings.										
c.	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% 0/12	0/2	0/2	0/2	0/2		0/2		0/2	
d.	Individual receives a quality quarterly nursing record review.	0% 0/6	0/1	0/1	0/1	0/1		0/1		0/1	
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	100% 6/6	1/1	1/1	1/1	1/1		1/1		1/1	
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2		0/2		0/2	
g.	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.	71% 5/7	N/A	1/1	2/2	2/2		0/2		N/A	

Comments: a. It was positive that all six annual nursing record reviews for individuals in the review group included, as applicable, the following:

- Active problem and diagnoses list updated at the time of annual nursing assessment (ANA); and
- Consultation summary.

Most, but not all included, as applicable:

- Procedure history;
- List of medications with dosages at the time of the ANA;
- Lab and diagnostic testing requiring review and/or intervention;
- Tertiary care; and
- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history; and
- Immunizations.

Of note, many of the annual nursing record reviews included many of the required components. Two of them (i.e., Individual #64, and Individual #51) were only missing complete immunization information. With minimal effort, nurses could make continued progress on the quality of the annual nursing record reviews.

b. and e. It was positive that for the six individuals reviewed, nurses completed annual and quarterly physical assessments that addressed the necessary components.

c. and f. For six individuals, the Monitoring Team reviewed a total of 12 IHCPs addressing specific risk areas (i.e., Individual #64 – constipation/bowel obstruction, and circulatory; Individual #31 – constipation/bowel obstruction, and fractures; Individual #51 – seizures, and falls; Individual #85 – GI problems, and infections; Individual #114 – cardiac disease, and respiratory compromise; and Individual #77 – diabetes, and respiratory compromise).

Overall, none of the annual comprehensive nursing or quarterly assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. However, on a positive note, nurses included status updates, including relevant clinical data, for about a third of the risk areas reviewed in the annual assessments (i.e., Individual #64 – constipation/bowel obstruction; Individual #31 – constipation/bowel obstruction; and Individual #77 – diabetes, and respiratory compromise), and for about a half of the risk areas reviewed in the quarterly assessments (i.e., Individual #64 – constipation/bowel obstruction, Individual #31 – constipation/bowel obstruction, Individual #51 – seizures, Individual #114 – respiratory compromise, and Individual #77 – respiratory compromise).

Unfortunately, nurses generally had not analyzed this information (i.e., the one exception was Individual #64 – constipation/bowel obstruction), including comparisons with the previous quarter or year. Nurses also had not made necessary 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.

d. It was positive that all of the most recent quarterly nursing record reviews for individuals in the review group included the following, as applicable:

- Active problem and diagnoses list updated at the time of the quarterly assessment;
- List of medications with dosages at the time of the quarterly nursing assessment;
- Consultation summary; and
- Lab and diagnostic testing requiring review and/or intervention.

Most, but not all of the most recent quarterly nursing record reviews for individuals in the review group included, as applicable:

- Procedure history;
- Tertiary care; and
- Allergies or severe side effects to medication.

The components on which Center staff should focus include:

- Family history;
- Social/smoking/drug/alcohol history; and
- Immunizations.

g. The following are examples of when assessing exacerbations in individuals' chronic conditions (i.e., changes of status), nurses adhered to nursing assessment guidelines in alignment with individuals' signs and symptoms:

- According to an IPN, dated 7/14/21, at 9:40 a.m., after staff reported that Individual #31 was limping, nursing staff conducted an assessment consistent with relevant nursing guidelines. Assessment findings included mild swelling, no redness or skin breakdown, that the individual was guarding the foot, and a FLACC pain scale rating of 2/10. The nurse notified the PCP. At 2:30 p.m., the nurse contacted the PCP again with a reminder that a PCP assessment was needed, and reported that the individual continued to limp. On 7/15/21, an x-ray showed a right foot metatarsal fracture.
- On 8/24/21, at approximately 12:00 p.m., Individual #51 experienced a seizure. Once notified, nursing staff conducted an assessment. Based on the findings, which included abnormal vital signs as well as continued twitching of his arms, the nurse contacted the PCP. The PCP recommended one-to-one staffing. At 12:30 p.m., the individual began to have another seizure. The nurse contacted the PCP, who ordered the administration of Ativan intramuscular (IM). At 12:35 p.m., nursing staff administered the Ativan. The PCP ordered the individual's transport to the ED via EMS. Throughout this episode, nursing staff followed nursing assessment guidelines and PCP notification guidelines.
- On 9/27/21, Individual #51 fell as he was "reaching for an item on the floor and tipped over. He hit his head." Nursing staff followed the assessment guidelines for falls, and notified the PCP. The PCP assessed the individual and ordered mild head injury assessments, which nursing staff initiated.
- On 9/2/21, at 8:00 a.m., nursing staff noted that Individual #85's gastrostomy tube (G-tube) malfunctioned. Specifically, the balloon was deflated and ruptured. The nurse assessed the individual's vital signs and the stoma site, and completed a head-to-toe assessment. The nurse notified the PCP, who ordered the individual's transport to the ED. Nursing staff followed applicable nursing guidelines.
- On 6/9/21, at 1:34 p.m., nursing staff documented an assessment of Individual #85 in response to redness to her right eye and above her eyebrow. The nurse followed applicable guidelines. The PCP saw the individual and ordered treatment for blepharitis.

The following provide a examples of concerns related to nursing assessments in accordance with nursing guidelines or current standards of practice in relation to exacerbations in individuals' chronic conditions (i.e., changes of status):

- According to a flow sheet, on 7/1/21, at 6:26 a.m., Individual #114's blood pressure was 116/57. At 8:00 a.m., a re-assessment showed the individual's blood pressure was 123/78. While it was positive that nursing staff reassessed the individual after the finding of low blood pressure, the nurse did not write an IPN to identify the out-of-range blood pressure, document the nursing plan to reassess the individual, and/or describe an assessment to determine whether or not the individual was symptomatic or had any complaints.
- For Individual #114, in an IPN, dated 10/7/21, at 10:27 p.m., a nurse stated: "At approx 2045 client was seen in room regarding the swallowing of a foreign object, it was noted that when client spoke her voice sounded as if there was indeed an object in her throat, client at this time is agitated but is breathing normally with bilateral chest rise and fall at this time, client is non-cyanotic at this time, breathing is unlabored and client does not appear in respiratory distress, Sp02 is 100% at this time, object was observed in client's throat and, as she stated object appeared to be a knob from her walker, nursing was unable to and did not attempt to retrieve object, on call NP was notified and order was received to send to [hospital] via EMS, campus admin was also notified of situation, nursing remained with client until EMS arrival, client condition was unchanged at

the time of EMS arrival." The nurse did not assess and/or document the individual's respiratory rate or other vital signs. Nursing staff did not follow the guidelines for pica/respiratory assessment.

Outcome 5 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Summary: Similar to the previous review, Center staff sustained some of their progress with regard to the inclusion of nursing interventions in individuals' IHCPs. Staff are encouraged to continue these efforts with particular focus on including a thorough set of interventions that are measurable. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/12	0/2	0/2	0/2	0/2	N/R	0/2	N/R	0/2	N/R
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/12	0/2	0/2	0/2	0/2		0/2		0/2	
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/12	0/2	0/2	0/2	0/2		0/2		0/2	
d.	The IHCP action steps support the goal/objective.	0% 0/12	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).	33% 4/12	2/2	0/2	1/2	0/2		0/2		1/2	
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	50% 6/12	2/2	0/2	1/2	0/2		1/2		2/2	

Comments: a. through f. The IHCPs reviewed all included nursing interventions, but were missing key nursing supports. For example, while many of the IHCPs reviewed included nursing assessment interventions, nursing staff often had not individualized these ongoing nursing assessments to meet individuals' needs (e.g., to reflect individuals' specific seizure management plans, needs for fluid intake, monitoring of residuals, etc.). In addition, often, the IDTs had not included in the action steps nursing assessments/interventions to address the underlying cause(s) or etiology(ies) of the at-risk or chronic condition (e.g., if an individual had poor oral hygiene, a nursing intervention to evaluate the quality of the individual's tooth brushing, and/or assess the individual's oral cavity after tooth brushing to check for visible food; if an individual's positioning contributed to her aspiration risk, a schedule for nursing staff to check staff's adherence to the positioning instructions/schedule; if an individual's weight loss was due to insufficient intake, mealtime monitoring to

assess the effectiveness of adaptive equipment, staff's adherence to the Dining Plan, environmental factors, and/or the individual's food preferences, etc.).

Overall, as discussed during the remote review with the Chief Nurse Executive (CNE)/RNCM supervisor, and the State Office Nursing Discipline Lead, Center staff were not familiar with the email that the previous State Office Nursing Discipline Lead sent related to using specific terminology in IHCP interventions to designate when nurses should conduct assessments (e.g., for weekly assessments, designating what day of the week). The State Office Nursing Discipline Lead followed up with the staff, and explained that these would be incorporated into nursing policy. Significant work is still needed to include nursing interventions that meet individuals' needs into IHCPs.

b. IHCPs generally did not include preventative interventions. In other words, they did not include interventions for staff and individuals to proactively address the chronic/at-risk condition. Examples might include drinking a specific amount of fluid per day to prevent constipation, washing hands before and/or after completing certain tasks to prevent infection, etc.

e. The IHCPs that included specific clinical indicators for measurement were for: Individual #64 – constipation/bowel obstruction, and circulatory; Individual #51 – falls; and Individual #77 – diabetes.

f. The IHCPs that identified the frequency of monitoring/review of progress were for: Individual #64 – constipation/bowel obstruction, and circulatory; Individual #51 – falls; Individual #114 – respiratory compromise; and Individual #77 – diabetes, and respiratory compromise.

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: Timely referral occurred for one of the two individuals requiring referral to the PNMT. It was positive that for the individual who required a PNMT review, the PNMT completed it timely, and it met the criteria for quality and thoroughly addressed the individual's needs. The other individual required a comprehensive PNMT assessment, which the PNMT completed timely. While it met a number of the criteria for quality, key elements of the assessment did not meet the individual's needs. Due to the Center's sustained compliance with the completion of timely PNMT assessments (i.e., Round 15 – 100%, Round 16 – 100%, and Round 17 – 100%) , Indicator c will move to the category requiring less oversight. The remaining indicators will continue in active oversight. In addition, if the Center sustains its	Individuals:

progress, then after the next review, Indicators b, and d might also move to the category requiring less oversight.											
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	50% 1/2	N/A	N/A	1/1	N/A	0/1	N/A	N/A	N/A	N/A
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	100% 1/1			N/A		1/1				
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 1/1			1/1		N/A				
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	100% 2/2			1/1		1/1				
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	N/A			N/A		N/A				
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	50% 1/2			1/1		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.	100% 1/1			N/A		1/1				
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/1			0/1		N/A				
Comments: a. through g. For the two individuals that should have been referred to and/or reviewed by the PNMT: • In June 2021, Individual #51 fell three times, and again in July 2021, he fell three times. On 7/3/21, he fell from his wheelchair due to a possible seizure, hitting his head on the concrete patio, and was unresponsive. He was hospitalized with a discharge diagnosis of a breakthrough seizure. On 8/23/21, after an additional three falls, he was referred to the PNMT, and on 8/26/21, the PNMT initiated an assessment. Since his referral, he fell an additional six times. On 9/27/21, the PNMT completed its assessment. The quality of the assessment is discussed below.										

- On 7/13/21, Individual #139 weighed 129.6 pounds. By 8/11/21, he had lost 11.6 pounds (i.e., a 9%-weight loss in one month). By 9/13/21, he lost an additional 5.5 pounds. On 9/16/21, he was referred to the PNMT for unplanned weight loss of 15.1 pounds (12%), since 7/13/21. At least on 8/11/21, the IDT should have referred him to the PNMT or the PNMT should have made a self-referral, because he had exceeded the criterion of a 5%-loss in one month.

  On 9/23/21, the PNMT conducted a review. Only the PNMT RN signed the review, so it was difficult to determine who participated in it. The review was thorough, and met the individual's needs. The PNMT identified that his weight loss was related to meal refusals, which staff were not documenting. Apparently, he would engage in behaviors, including resisting prompts, physical aggression, and refusals to get out of bed. The recommended plan was designed to correct staff's failure to document his refusals, and communication strategies to address the refusals.

  From 12/20/20 through June 2021, he experienced a gradual weight loss. Then, as of 8/11/21, he experienced significant weight loss. The PNMT did not report results of reweighing him for equal to or more than a five-pound weight loss from the previous weight. Staff only weighed him monthly until a PCP order to weigh him weekly, dated 9/13/21. The order was confusing and stated: "reweigh the following day if weight is +/- 5 lbs from previous day's weight").

h. It was positive that Individual #51's PNMT assessment thoroughly addressed the following:
- Presenting problem;
- Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- The individual's behaviors related to the provision of PNM supports and services;
- Discussion of medications that might be pertinent to the problem, and discussion of relevance to PNM supports and services;
- Evidence of observation of the individual's supports at his/her program areas;
- Discussion as to whether existing supports were effective or appropriate; and
- Identification of the potential causes of the individual's physical and nutritional management problems.

Some of the concerns with the assessment included:
- The discussion of pertinent diagnoses, medical history, and current health status did not include discussion about his diagnoses' specific impact on his PNM needs.
- With regard to the assessment of the individual's current physical status, the PNMT only cited findings from other assessments, they did not appear to conduct their own assessments. They presented some data as the possible causes of his falls, but they had not previously reported them in the assessment. For example, the PNMT cited staff not buckling his seatbelt as a possible cause, or even unbuckling it, but the assessment did not provide/establish specific data to support this hypothesis. They indicated that the individual did not receive his target fluids, which could impact his seizures and result in falls. However, they should have provided data related to his baseline food and fluid intake and history of meal refusals reported from June through September, and cited any correlation between fall occurrences and low fluid intake.
- The recommended goals were related to the individual wearing his helmet and seat belt while self-propelling his wheelchair. The IDT would measure the individual's progress via monitoring. However, the PNMT reported that monitoring revealed 100% compliance, but the PNMT's own observations and staff reports were that the individual often did not wear the seatbelt, and in fact, staff believed that applying it was a restraint. Many of his falls occurred when he was seated in his wheelchair and

outside, not in his home or at the Education and Training (E&T) building, and not while he was self-propelling his wheelchair. In addition, the goal on which the PNMT was reporting for monitoring did not match the goal they outlined in their assessment.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. The plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause(s) or etiology(ies) of the PNM issues in the action steps. In addition, many action steps were not measurable. Seven out of nine PNMPs reviewed met the requirements for quality. Given that during the previous review, the Center's score was 67%, and problems noted during that review as well as this review were minimal, if the Center sustains its progress overall, then, after the next review, Indicator c might move to the category requiring less oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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).	12% 2/17	0/2	0/1	1/2	0/2	0/2	0/2	0/2	1/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	29% 5/17	0/2	0/1	1/2	0/2	1/2	1/2	1/2	0/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/17	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/17	0/2	0/1	0/2	0/2	0/2	0/2	1/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	12% 2/17	0/2	0/1	0/2	0/2	0/2	1/2	0/2	1/2	0/2
Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #64 – constipation/bowel obstruction, and falls; Individual #31 – falls, and constipation/bowel obstruction (i.e., did not require PNM supports for this risk); Individual #51 – falls, and											

choking; Individual #85 – aspiration, and falls; Individual #139 – falls, and weight.; Individual #114 – falls, and choking; Individual #83 – skin integrity, and choking; Individual #77 – falls, and choking; and Individual #59 – choking, and falls.

a. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The exceptions were for: Individual #51 – choking, and Individual #77 – choking.

b. Overall, ISPs/IHCPs reviewed did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were for Individual #51 – choking, Individual #139 – falls, Individual #114 – choking, Individual #83 – choking, and Individual #59 – choking.

c. All individuals reviewed had PNMPs and/or Dining Plans. Seven of the nine PNMPs/Dining Plan fully met the individuals' needs.

- Individual #64's PNMP met most of the criteria for quality. The only problem was that the communication section did not provide a description of his verbal communication.
- Individual #83's PNMP should have updated to address his skin integrity issue (i.e., pressure injury to his heel), but it was not.

Given that during the previous review, the Center's score was 67%, and problems noted during that review as well as this review were minimal, if the Center sustains its progress overall, then, after the next review, Indicator c might move to the category of less oversight.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #83 – choking.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring/review of progress. Those that did were for: Individual #114 – choking, and Individual #77 – choking.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/1				0/1					

Comments: a. and b. Individual #85's IDT did not provide sufficient justification for the continued use of enteral feeding. They stated only that a modified barium swallow study (MBSS) indicated she was not currently safe for oral feedings. They provided no date for the study, and did not report the findings. As a result, it was unclear whether or not a plan was needed to assist the individual along the continuum to oral intake.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: Seven of the nine individuals in the review group received timely OT/PT assessments that were of the correct type based on their needs. Center staff should ensure the completion of assessments when individuals experience changes of status. Given the Center's sustained progress in completing timely assessments for newly-admitted individuals (Round 13 – 100%, Rounds 14 – 100%, Round 15 – and 16 – N/A, and Round 17 – 100%), Indicator a.i will move to the category requiring less oversight. The quality of OT/PT assessments continues to be an area on which Center staff should place considerable focus.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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	1/1	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	75% 6/8	1/1	1/1	0/1	1/1	1/1	0/1	N/A	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	75% 6/8	1/1	1/1	0/1	1/1	N/A	0/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following:	N/A									

	• Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	N/A									

Comments: a. through c. As applicable, many, but not all, individuals reviewed received timely OT/PT reassessments that were also of the correct type based on their needs and any changes of status. The following describes the exceptions noted:

- For Individual #51, Center OT/PT staff did not complete an assessment to address the high frequency of falls that occurred since his annual ISP meeting on 12/1/20. According to documentation provided, from May 2021 through September 2021, he fell at least 17 times.
- For Individual #114, Center OT/PT staff did not complete a change of status post-hospitalization assessment as needed. On 5/27/21, the PT completed a brief IPN related to observing her use a walker and gait belt, and recommended continued use of the gait belt, with re-assessment in two weeks. Although, on 6/25/21, the PT followed up and indicated that the gait belt should be discontinued, these IPNs did not constitute an assessment, based on her needs. For example, the PT IPN, dated 5/27/21, stated that the individual had been hospitalized a few weeks earlier, but did not state when she returned, why she was hospitalized, or for how long. It further noted the individual returned from the hospitalization in a lethargic state, and nursing notes from 5/12/21, corroborated that she was lethargic and drooling upon her return. The PT IPN did not address the possible causes or potential impact on her mobility or other OT/PT-related functioning, even though a gait belt was recommended for both indoor and outdoor ambulation with her walker. The PT did not make reference to a fall the previous day (5/26/21). However, Center nursing staff reported muscle weakness during the nursing post-fall assessment IPN, dated 5/27/21. The PT's IPN did not note any circumstances related to this fall.

d. None of the nine comprehensive assessment reviewed met all criteria for a quality assessment. While some improvement was noted, substantial work is still needed to improve OT/PT assessments to ensure that they meet individuals' needs. The Center needed to continue to focus on all of the sub-indicators described below:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- 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);
- 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;
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; 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.

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: Improvement is needed with regard to all of these indicators. To move forward, OT/PT assessments need to consistently include recommendations for necessary OT/PT strategies, interventions and programs. In addition, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	1/1	1/1	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.	33% 3/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	1/1

c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	33% 1/3	N/A	N/A	N/A	0/2	1/1	N/A	N/A	N/A	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: a. Three of nine ISPs reviewed did not include concise, but thorough, descriptions of individuals' OT/PT functional statuses. The following describes concerns noted:

- For Individual #85, the ISP documented very little information about her OT/PT-related functioning, but instead focused primarily on the supports Center staff provided and diagnoses. The ISP also stated that a PT performed an evaluation on 4/16/21, to address "his" frequent falls. This information did not pertain to her at all.
- The ISPs for Individual #139 and Individual #59 contained limited discussion of their motor performance.

In its comments on the draft report, the State disputed the findings for Individual #85, and Individual #59, and quoted sentences from their ISPs. As indicated in the interpretive guidelines of the audit tool: "The description should be a functional description of the individual's fine, gross, oral, and sensory motor skills, activities of daily living skills, and mobility strengths and needs. Plans should include clear descriptions of how the individual uses assistive/adaptive equipment." Neither of these ISPs met these guidelines. For example, at times, the descriptions described the individual's motor deficits without describing their skills.

b. Only three of nine ISPs reviewed documented a meaningful review of the individuals' PNMP and/or Positioning Schedule. Often, ISPs included only a partial list of the elements of the PNMPs with little to no discussion of the effectiveness of the strategies. At times, IDT concluded that strategies were effective, despite ongoing PNM concerns, such as falls.

In its comments on the draft report, the State disputed this finding for Individual #31, and listed multiple changes to his PNMP that were included in the ISP. However, in the assessment the OT/PT did not make any recommendations to modify the individual's PNMP, yet listed all of these changes. The clinicians provided no discussion as to the effectiveness of the PNMP, so it was not clear how they concluded that it was effective. There was no evidence of monitoring for compliance or effectiveness noted in the assessment, beyond the plate guard and the shower chair. They did not outline how frequently monitoring took place. It was not clear that the IDT discussed these items. The OT/PT assessment indicated that he had two falls and that he was at risk for falls in the shower when not using the shower chair.

c. and d. The IDT for Individual #85 did not integrate the OT/PT goals/objectives recommended in her assessment. In its comments on the draft report, the State disputed this finding, and cited page 12 of Individual #85's ISP. They referenced that the ISP listed four goals, and included the following statement: "PT requested to provide direct services from May 10 to August 31, 2021 with a frequency of 2x per week." While the ISP did make these statements, on page 12, it also stated: "Direct services are not being recommended at this time as she is too frail for direct services and does not adhere to verbal directions." In addition, the IDT linked these goals, which were related to elbow extension, and sitting at the edge of the bed, with her aspiration risk. No rationale was provided to explain how the

proposed therapeutic interventions were connected to her aspiration risk. Moreover, the monthly summary, under aspiration risk, only included the sitting on the edge of bed goal, and indicated that others would be added as she mastered that one. That is not how therapy goals should be structured. Generally, multiple goals are worked on at a time and participation in one activity contributes to the others. They are connected and not necessarily sequential.

However, it was positive that for the one individual for whom a new OT/PT service or support was initiated (i.e., a gait belt for Individual #114), the IDT met to discuss and approve its implementation.

As applicable, OT/PT assessments did not consistently include recommendations for OT/PT-related strategies, interventions and programs. This ongoing problem also contributed to individuals' IHCPs/ISPs not including necessary action steps. OTs/PTs should work with QIDPs to ensure assessments provide the needed recommendations for IDTs to consider.

Communication

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

Summary: Individuals reviewed received timely communication assessments that were of the correct type in accordance with their needs. If the Center sustains it performance for the next Round, indicators a.ii and a.iii might move to the category requiring less oversight. However, work is still needed to improve the quality of communication assessments and updates in order to ensure that AAC options are fully explored, and that IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	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.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A

	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1	N/A	N/A	N/A
b.	Individual receives assessment in accordance with their individualized needs related to communication.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	50% 1/2	0/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/5	N/A	0/1	0/1	0/1	0/1	N/A	0/1	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments: a.ii and a.iii. The applicable individuals reviewed received timely assessments.

c. For one of two applicable individuals reviewed, Center staff did not complete a quality screening. The screening for Individual #64, completed on 6/1/21, noted that a hearing exam on 2/17/20, revealed sensorineural hearing loss, but did not describe the degree of loss, whether it affected both ears and/or whether hearing was better in one ear than the other. The screening stated that the individual was able to hear staff and peers when they were in close proximity and that he did not wear hearing aids. However, the screening provided no further description about his ability to hear when others were not in close proximity or whether hearing aids had been considered or trialed.

In its comments on the draft report, the State disputed this finding for Individual #64, and stated: "At the time of the screener, in 2021, the ENT specialist did indicate, per TX-RG-2III-II.70 #64, that the SNHL effected [sic] both ears. This was noted in TX-RG-2111-II.78 #64 on pg. 1 section I (Medical History). Furthermore, his hearing is thoroughly addressed (covering all required components) as

evidenced below…" The State then quoted various sections of the screening. The SLP did not address the severity of loss per the hearing exam specifically related to function. They did not address the fact that he had a bilateral hearing loss significant enough to need hearing aids, yet did not wear them. They also did not address the issue of when someone was not in his proximity and how that might impact his hearing/ability to communicate. No communication strategies were developed/recommended to address these issues.

d. None of the five comprehensive assessments reviewed met all applicable criteria for a quality assessment. However, it was positive that all five assessments met most criteria. With focus in on the criteria identified below as needing attention, Center staff could make good progress by the time of the next review. All five met criteria for the following components:

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

Most of the assessments also included a discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

The Center should focus most on the following components:

- 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; 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.

  In its comments on the draft report, the State disputed this finding for the five individuals with 0 scores for Indicator d. The rationale they provided was essentially the same for each of the five individuals. In sum, the State indicated that these individuals had communication strategies that were in their "ME books," as well as their PNMPs. "These communication supports are also integrated with the collaboration between SLPs and Behavioral Health into their behavioral plan… which is noted in the communication assessments… as well as in the ISP guide... The IDT members attend ISPs and are made aware of these supports… Communication supports are integrated in all aspects of the individual's day and not just in the SAPs." For each of these individuals, the recommendation section of the communication assessments were problematic due to either the lack of recommendations to address unmet needs identified in the assessments, and/or incomplete assessment of their communication needs, making it unclear whether or not additional recommendations were warranted.

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: It was positive that for most applicable individuals, IDTs documented a thorough review of their functional communication skills and their Communication Dictionaries. As a result of the Center's sustained progress [i.e., Round 15 – 100%, Round 16 – 100%, and Round 17 – 80% (4/5)], Indicator b will move to the category requiring less oversight. If the Center sustains its progress, after the next review, Indicator a might move to the category requiring less oversight. However, additional work was still needed to ensure that ISPs included strategies, interventions and programs recommended in the assessment. The remaining indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
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.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	80% 4/5	N/A	1/1	1/1	1/1	0/1	N/A	1/1	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.	50% 2/4	N/A	N/A	0/1	1/1	1/1	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									

Comments: a. through c. For most individuals reviewed, it was positive their ISPs provided complete functional descriptions of their communication skills and documented a thorough review of their Communication Dictionaries. The exception was for Individual #139, whose ISP did not provide information about how staff should communicate with him or document what the IDT reviewed, revised, and/or approved with regard to his Communication Dictionary, including whether the current version was effective at bridging the communication gap.

c. It was positive that the IDTs for Individual #85 and Individual #139 included their goals/objectives in their ISPs. However, the IDT for Individual #51 deferred implementation of his recommended goal/objective (i.e., sign shower) and the IDT for Individual #83 did not approve his recommended goal/objective (i.e., press "shower" button). Based on interviews with Center staff, in both instances, it

appeared the rationale for these decisions was insufficient because it was based on the number of other SAPs the individuals had (i.e., no more than three active SAPs at a time), rather than on their individual communication needs and their individual capacity for participation in skill acquisition. In addition, IDTs should give careful consideration to proposed communication goals/objectives as this is often a key area for skill acquisition that might impact many aspects of their days and lives.

In its comments on the draft report, the State disputed the findings for Indicator c for Individual #85, and Individual #139, which were rated as 1s in the draft report.

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: There were few SAPs, though each individual had at least one. Most were not written in measurable terminology and none had reliable data. Most were based on assessment results, as was the case for the previous two reviews, too. Therefore, indicator 3 will be moved to the category of requiring less oversight. The others will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	12% 2/16	0/1	0/3	1/2	0/3	0/1	0/2	0/1	0/1	1/2
3	The individual's SAPs were based on assessment results.	88% 14/16	1/1	3/3	1/2	2/3	1/1	2/2	1/1	1/1	2/2
4	SAPs are practical, functional, and meaningful.	44% 7/16	0/1	1/3	0/2	2/3	1/1	1/2	0/1	0/1	2/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/16	0/1	0/3	0/2	0/3	0/1	0/2	0/1	0/1	0/2

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. Individual #29, Individual #43, Individual #64 and Individual #31 had one SAP. Individual #97, Individual #70, and Individual #148 had two SAPs each, for a total of 16 SAPs.

2. Individual #97's brush his teeth SAP and Individual #148's revised identify pictures SAP contained a clear behavioral objective. The remaining 14 SAPs had unclear objectives. For example, the training objective for Individual #64's turn on his CD player read "Individual #64 will turn on his CD player independently in 80% of trials." This objective did not include how long he needed to

maintain this skill at this prompt level. A complete behavioral objective might read "Individual #64 will turn on his CD player independently in 80% of trials per session for three consecutive months."

3. Individual #148's FSA indicated that he could independently brush his teeth. Neither Individual #17's FSA nor SAP training sheet documented baseline data for applying eye drops.

4. Because available assessments indicated that Individual #148 could independently brush his teeth, this SAP was determined to not be a functional SAP for him. Other SAPs were scored as not practical or functional because they were not clearly related to the individual's ISP vision statement (e.g., Individual #43's lather her hands SAP), or likely represented a compliance plan rather than a skill acquisition plan (e.g., Individual #70's name his medication SAP).

5. There were no IOA assessments to show or document that the SAP data were reliable.

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

Summary: Performance remained about the same for a number of consecutive reviews. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
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.	22% 2/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	78% 7/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1

Comments:

11. Individual #97, Individual #29, Individual #43, and Individual #144's vocational assessments were late. Individual #64, Individual #17, and Individual #31's FSA's were not available to the IDT at least 10 days prior to their ISPs.

12. Individual #64's vocational assessment, and Individual #43's FSA did not include 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, 28 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, six other indicators were added to this category, in the areas of restraint management, psychiatry, behavioral health, and nursing. Two indicators did not maintain performance and were returned to active monitoring, in the areas of pharmacy and dental.

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

Goals/Objectives and Review of Progress

In behavioral health, one of the individuals for whom there were reliable data was making progress. With improvements in IOA and DCT, progress can be assessed and reported for additional individuals. When goals are deemed met, they need to be updated, and when there is no progress, actions should be considered and taken if deemed needed.

Behavioral health services progress notes were regularly being done.

Acute Illnesses/Occurrences

If not receiving psychiatric services, a Reiss was conducted.

When there were more than three crisis intervention restraints in a rolling 30-day period, IDT and BHS reviews did not contain all of the required content.

Psychiatry staff took action for individuals who were not meeting treatment goals or who were not considered psychiatrically stable.

It was positive that for each of the six acute illnesses/occurrences reviewed, nurses performed initial nursing assessments in accordance with applicable nursing guidelines. It also was good to see that for the acute illnesses/events for which individuals were transferred to the Emergency Department (ED) or hospitalized, nurses conducted pre- and post-hospitalization assessments. Overall improvements continued with the quality of acute care plans. In two of the five cases, nursing staff thoroughly implemented the plans. Center staff should continue their efforts to make needed improvements to the quality of the plans and their implementation.

Overall, as indicated in previous reports, the quality of medical practitioners' assessments of individuals with acute issues treated at the Center did not meet generally accepted standards of care. In most instances reviewed, PCPs also did not conduct proper follow-up of acute issues addressed at the Center. Some improvement was noted, though, with assessments prior to, as well as follow-up after individuals' returns from acute care settings.

Implementation of Plans

Collaboration between psychiatry and neurology regarding the consideration of a medication for dual use was not done.

In psychiatry, there was improvement to 100% for quarterly review documentation content. Some additions to the psychiatry clinic protocols, however, were needed.

For individuals with psychotropic medication polypharmacy, they were reviewed as required.

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

PBSP graphs were present, but half were missing important life events.

In behavioral health, attention to clinical and review meeting data and follow-up was needed. That being said, a very good internal peer review meeting was observed by the Monitoring Team.

IHCPs generally included some, but not all necessary nursing supports. Even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks.

Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For four of the 18 chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and identified the necessary treatment(s), interventions, and strategies, as appropriate.

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. For 14 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. However, for three of the four remaining IHCPs reviewed, documentation was found to show implementation of those few action steps that IDTs had assigned to PCPs and included in IHCPs/ISPs. Until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

For four of the 13 non-facility consultations reviewed, Center staff did not submit the reports from the consultants. An additional three reports arrived more than two weeks after the appointments. It was not clear what efforts staff made to obtain the reports sooner. Efforts are needed to improve the Center's system for tracking consultation reports and recommendations.

Individuals reviewed did not consistently receive necessary dental care on a timely basis. In addition, due to problems noted during the past two reviews with the provision of dental x-rays, the related indicator will return to active oversight.

For the nine individuals in the review group, three of 17 Quarterly Drug Regimen Reviews (QDRRs) were completed timely. At the time of the last review, problems also were noted with timeliness, and the Monitor recommended that staff put procedures in place to correct the problems. Given that the problem worsened, the related indicator will return to active oversight. More work also is needed on the quality of the QDRRs, particularly with regard to the laboratory sections. PCPs and psychiatrists also need to review QDRRs timely to avoid additional indicators returning to active oversight.

Center staff continued to do well with the administration of medications as prescribed. During about half of the medication administration observations, when issues arose with regard to infection control practices, the Center's nurse auditor identified the same issues as the Monitoring Team member, and took steps to address them, as necessary.

Since the last review, Center staff sustained their improvement with regard to the inclusion in IHCPs of respiratory assessments for individuals at high risk for respiratory compromise. However, nurses need to implement these interventions.

Improvements also are needed in terms of the timely reporting of medication variances, nurses adhering to infection control practices, and providing instructions to individuals and staff when new medications are administered or when orders change.

Based on observations, some adaptive equipment was not in proper working condition, and for about half the individuals, the equipment did not appear to be the proper fit.

Based on observations, there were still numerous instances (62% of 38 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, or ate at an unsafe rate, or staff not ensuring the texture of the food was correct) placed individuals at significant risk of harm. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Center staff should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.											
Summary: Reviews of when there were more than three crisis intervention restraints in a rolling 30-day period did not contain all of the required content (indicators 20 and 22). Indicator 29, however, showed sustained high performance and will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	70								
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/1	0/1								
21	(No longer scored)										
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.	100% 1/1	1/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 1/1	1/1								
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	100% 1/1	1/1								
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.	100% 1/1	1/1								
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.	100% 1/1	1/1								

Comments:
18. Individual #70's had 10 restraints on 4/15/21. The ISPA to review these restraints was dated 5/19/21.

20. Individual #70's adaptive skills and biological and medical issues were discussed by the IDT, however, there was no indication if the team hypothesized that these skills and issues contributed to the dangerous behavior that provoked his restraints.

22. Individual #70's ISPA hypothesized that the provocation by a peer may have been an antecedent to his aggression. Actions to address this potential antecedent to his dangerous behavior was not, however, documented in the ISPA.

27. The CIP was well-written, complete, and clearly written; one of the best seen by the Monitoring Team.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: With sustained high performance, these indicators might be moved to the category of requiring less oversight after the next review. It was good to see 100% performance for this review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2								1/1	
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A									

3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A										

Comments:
1-3. Two of the 16 individuals reviewed by both Monitoring Teams, Individual #29 and Individual #85, were not receiving psychiatric services, in both cases a Reiss Screen was required and completed. Neither Individual #29 nor Individual #85 required further evaluation as evidenced by their Reiss Screen score.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: While Rio Grande SC has developed goals for indicators for reduction and there were data for psychiatric indicators for reduction, there were no data regarding the indicators/goals for increase. Therefore, it was not possible to determine progress toward goals for indicators for increase. As such, indicators 8 and 9 cannot be thoroughly assessed by the Monitoring Team. The Monitoring Team acknowledges the efforts of the psychiatry staff in taking action for individuals who are not meeting treatment goals or who are not considered psychiatrically stable. Given high sustained performance regarding the latter, indicators 10 and 11 will be moved to the category of requiring less oversight. Indicators 8 and 9 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
8	The individual is making progress and/or maintaining stability.	0% 0/7	1/2	1/2	1/2	1/2	1/2	1/2			1/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	100% 2/2				1/1		1/1			
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 4/4			1/1			1/1	1/1		1/1
11	Activity and/or revisions to treatment were implemented.	100% 4/4			1/1			1/1	1/1		1/1

Comments:
8-9. Per a review of the individual's indicators as well as available data, there were six individuals, Individual #31, Individual #144, Individual #148, Individual #17, Individual #64, and Individual #70 who were making progress with regard to their identified indicators for reduction. Individual #43 was a new admission as of July 2021, and her indicators/goals were recently developed, so it was too soon to determine progress. With regard to progress for indicators for increase, there was documentation that Individual #97 was meeting the goal regarding outing attendance.

There were two individuals, Individual #17 and Individual #70, who had adjustments to their indicators/goals. Individual #17 was not meeting the goal regarding an indicator for increase requiring him to engage in deep breathing exercises, so this indicator/goal was

discontinued. As Individual #17 was reportedly meeting his goal regarding the indicator of outing attendance, the metrics for this goal were increased. Further, a new indicator for reduction, depression, was identified with an associated goal developed for Individual #17. As Individual #70 was meeting the goal for the indicator for reduction, the metrics for this goal were adjusted.

10-11. 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, environmental changes) were developed and implemented. There were four individuals in the review group, Individual #31, Individual #144, Individual #17, and Individual #64, who were noted per their treating psychiatric provider as psychiatrically stable and therefore did not require treatment adjustments, however, other individuals with this designation were noted to have adjustments to their medication regimen or behavior management program.

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

Summary: With sustained high performance, both indicators might be moved to the category of requiring less oversight after the next review. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
24	The psychiatrist participated in the development of the PBSP.	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	1/1		1/1

Comments:
23. The psychiatric documentation referenced the behavioral health target behaviors and the functional behavior assessment discussed the role of the psychiatric disorder upon the presentation of the target behaviors for all of the individuals in the review group.

24. Eight individuals in the review group had a PBSP implemented. Although there was documentation of the psychiatric nurse practitioner attending Behavior Support Committee on a regular basis and participating in the development of Behavior Support Plans, this was not evident in the example regarding Individual #148. When reviewing psychiatric clinical documentation, the information regarding the PBSPs was generic and formulaic. In the case of Individual #148, more documentation regarding his specific difficulties (e.g., refusal to leave his room) would be expected. When reviewing attendance records for Behavior Support Committee, the psychiatric nurse practitioner had attended 10 of the 18 meetings or 55% over the previous six months. This level of attendance should be improved.

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: These indicators applied to one individual and criteria were not met because collaboration regarding the consideration of a medication for dual use was not done. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	0% 0/1									0/1
26	Frequency was at least annual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	0% 0/1									0/1
Comments: 25-27. Per interviews with the psychiatric clinical staff, there were no individuals prescribed a dual-purpose medication at the facility. When reviewing records, there was conflicting documentation regarding the indication of Tegretol for Individual #97. There was documentation per neurology that the medication was solely for seizure disorder, but psychiatry must clearly note this as well. Overall, psychiatry clinic staff were making efforts to communicate with neurology and document the indication for medication.											

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: It was good to see improvement to 100% for quarterly review documentation content. Some additions to the psychiatry clinic protocols were needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1		1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	0% 0/2			0/1			0/1			
Comments: 34. The Monitoring Team looks for nine components of the quarterly review. All of the examples included all the necessary components. This was good to see. 35. During the virtual monitoring visit, psychiatry clinic was observed with the psychiatric nurse practitioner for two individuals, Individual #148 and Individual #70. The nurse practitioner was well prepared for clinic. One individual, Individual #70, was present											

for a portion of the clinical meeting, but he was not engaged in the clinical review. The nurse practitioner presented the clinical information and was noted to solicit information from the disciplines represented in the IDT. While overall the clinical encounters were appropriate with regard to the review of data, there was a need for improvement with regard to the discussion of the presented information and what that information meant clinically with regard to the need to adjust treatment interventions.

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

Summary: Performance was about the same as at the last review, that is, for some individuals assessments were not completed and/or reviewed timely. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	63% 5/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1		0/1

Comments:

36. There were delays in the completion of MOSES and DISCUS assessments and in the prescriber review for three individuals in the review group.

- For Individual #70, there was a DISCUS dated 10/24/20 with the next assessment dated 2/2/21. There should have been an assessment performed in January 2021.
- For Individual #43, the MOSES and DISCUS assessments completed 10/13/21 were not reviewed by the prescriber until 11/9/21.
- For Individual #97, the MOSES and DISCUS assessments dated 12/11/20 were not reviewed by the prescriber until 1/22/21.

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

Summary:

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

Comments:

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

Summary: Individuals:

#	Indicator	Overall Score									
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.										
42	There is a treatment program in the record of individual who receives psychiatric medication.										
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.										
	Comments:										

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Individuals were reviewed as required. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
45	There is a tapering plan, or rationale for why not.										
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 2/2						1/1			1/1
	Comments: Of the 56 individuals participating in psychiatry clinic at the facility, 29 individuals or 52% were prescribed medication regimens that met the definition of polypharmacy. 46. When reviewing the polypharmacy committee meeting minutes, there was documentation of ongoing, regular committee meetings. There was documentation of annual meetings and for Individual #97, who had a recent medication adjustment, there was documentation of quarterly polypharmacy review.										

The polypharmacy committee meeting was observed during the monitoring visit. The meeting was attended by psychiatry, primary care, behavioral health, and nursing staff. Overall, the meeting was a comprehensive review of the individual's regimen and their progress over the time period between reviews. The meeting did not include challenge to or discussion of the prescriber's rationale for a specific regimen. Generally, this meeting should be a brisk discussion of the regimens with the psychiatrist presenting the justification of polypharmacy for critique. Individuals should be scheduled for review annually, or quarterly if medication adjustments are made, or if there is an active medication taper in progress.

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: One of the individuals for whom there were reliable data was making progress. With improvements in IOA and DCT, progress can be assessed and reported in indicator 6 for additional individuals. When goals are deemed met, they need to be updated, and when there is no progress, actions should be considered and taken if deemed needed. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
6	The individual is making expected progress	14% 1/7	0/1	0/1	0/1	0/1	1/1	0/1			0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/3	0/1	0/1				0/1			
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	33% 1/3			0/1			1/1			0/1
9	Activity and/or revisions to treatment were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

6. Individual #64 's PBSP data were demonstrated to be reliable and he was making progress toward his PBSP objectives.

Individual #148, Individual #70 and Individual #97 were judged to not be making expected progress.

Individual #31, Individual #144, and Individual #17 were progressing, however, their indicators were scored as 0 because the PBSP data were not demonstrated to be reliable (see indicator 5).

7. Individual #31 achieved his objective for unauthorized departure in January 2021, and his SIB objective in December 2020, however, neither objective was updated. Individual #144 achieved his SIB objective in April 2021, and Individual #70 achieved his unauthorized departure objective in August 2021, but neither was updated.

8. Individual #70's aggression target behavior was not progressing, however, his July 2021 progress note suggested ensuring Individual #70 was engaged in more preferred activities to address the lack of progress. Individual #148 and Individual #97's target behaviors were also not progressing, however, there was no evidence that actions to address the lack of progress were identified.

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

Summary: Ensuring staff training on PBSPs was needed at the Center. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/8	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.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1		0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

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. Individual #144 and Individual #97 had no documentation of any PBSP training. Ensuring that all staff assigned to work with an individual have been trained on the implementation of the PBSP should be a priority.

17. None of the individuals had PBSP summaries.

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

Summary: Progress notes were regularly being done and with sustained high performance, indicator 19 might be moved to the category of requiring less oversight after the next review. Graphs were present, but half were missing important life events. Attention to clinical and review meeting data and follow-up was needed. That being said, a very good internal peer review meeting was observed by the Monitoring Team. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
19	The individual's progress note comments on the progress of the individual.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1	0/1		1/1
20	The graphs are useful for making data based treatment decisions.	50%	1/1	1/1	0/1	1/1	0/1	1/1	0/1		0/1

		4/8										
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	0% 0/2			0/1			0/1				
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	0% 0/1				0/1						
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months.	0%										

Comments:

19. Individual #43 did not have any progress notes.

20. Individual #97 and Individual #64 's graphs did not indicate when they had Covid-19, an event identified as potentially important in their BHAs. Individual #148's graphs did not reflect that he had dental problems in October 2021, an event identified as potentially affecting his target behaviors in his BHA.

21. In order to score this indicator, the Monitoring Team observed Individual #70 and Individual #148's psychiatric clinic meetings. Recent PBSP data were presented verbally, however, no graphed data were presented. The most recent data (e.g., over the last week or two) could be presented verbally, however, monthly data should be presented in graphic form, so the IDT can more easily see trends in the data and are, therefore, more likely to make data-based decisions.

22-23. Individual #17's 8/25/21 meeting labeled as peer review, appeared instead to be a review of his PBSP that was due for annual renewal. Peer review meetings should focus on reviewing individual's target behaviors, or skill acquisition plans, that are not progressing as planned, that is, not annual updates of the PBSP. In any event, the dates of the peer review meetings did not meet the criteria of at least three a month.

On a positive note, the Monitoring Team observed a peer review for Individual #100, which discussed sleep issues, and increased disruption. There was an excellent discussion by the Behavior Health team of the data and suggestions for the modification of current treatments. This meeting represented an excellent example of a peer review meeting.

Outcome 8 – Data are collected correctly and reliably.												
Summary: Overall, there was improvement in the data collection systems for target behaviors and replacement behaviors. Moreover, due to sustained high performance, indicator 29 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97

26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	71% 5/7	1/1	0/1	1/1	1/1	1/1	1/1			0/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	86% 6/7	1/1	1/1	1/1	1/1	1/1	1/1			0/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 7/7	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).	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1			1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	29% 2/7	0/1	0/1	1/1	0/1	1/1	0/1			0/1

Comments:

26. The Monitoring Team was encouraged to see that the data collection system for measuring undesired (target) behaviors was transitioning from a system that collected only partial interval data (i.e., the recording of only if the behavior occurred or not) in hourly or per shift intervals, to a system that collected the frequency of the target behaviors per interval.

At the time of the remote review, the frequency of Individual #70 and Individual #148's target and replacement data were collected hourly. The frequency of Individual #64 and Individual #31's behavioral data were collected once per shift. The use a frequency data collection system for these individuals represented a substantial improvement from the previous PBSP data collection system that only recorded the occurrence or nonoccurrence of the behavior being scored. All four of these individuals' data systems were judged to adequately measure their behavioral data. The frequency per shift system was judged adequate for Individual #64 and Individual #31 because their rates of target behaviors were very low.

The PBSPs indicated that Individual #17 and Individual #144's data collection had not yet transitioned to a frequency system, and consisted of recording occurrence or nonoccurrence of target behaviors at 60-minute intervals. Although simply recording if a behavior occurred or not each hour will likely result in an under-reporting of most target behaviors and, therefore, is not generally desirable, a 60-minute interval system can be adequate for individuals who engage in their target behaviors at a very low rate. Therefore, Individual #17's data system was scored as adequate. Individual #144's data collection system, however, was judged as inadequate because the rates of his target behaviors varied, and his rates in July 2021 were relatively high. Finally, Individual #97's data collection system was judged as inadequate because his behavioral data were recorded as occurring or not occurring only once a shift, and his rates of target behaviors were very high.

Utilizing a data system that is sensitive to each individual's behaviors is critical to affecting meaningful behavior change and, therefore, the Monitoring Team was encouraged to see the improvements in data collection from the last review. Although partial interval data collection may be appropriate for the collection of some target behaviors (e.g., Individual #17's PBSP data), for all of the individuals, their data systems would be improved if staff attempted to score the frequency of target behaviors within each interval.

27. The data collection system for measuring replacement behaviors utilized a data system that was identical to that for each individual's target behaviors (see indicator 26 comments). Although a system that measures the frequency of replacement behaviors is

likely to be the most sensitive, the collection of hourly occurrence or nonoccurrence of replacement behaviors (i.e., Individual #17 and Individual #144's replacement behavior) was judged as an adequate measure. Individual #97's, however, data system was scored as inadequate because the occurrence or nonoccurrence of replacement behaviors were scored only once a shift, and would not likely result in a sensitive measure of his replacement behaviors.

29. Rio Grande SC had established a schedule (once a quarter) and a minimum level (80%) of IOA, data collection timeliness, and treatment integrity for each individual's PBSP data.

30. Individual #64 and Individual #148 had IOA, data collection timeliness, and treatment integrity assessments at the level and frequency established in indicator 29. Individual #70's average IOA level over the last six months was below 80%. Individual #31, Individual #144, Individual #17, Individual #70, and Individual #97's data collection timeliness assessments all averaged less than 80% over the last 6 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 program needs to consistently assess (and retrain as necessary) IOA, data collection timeliness, and treatment integrity.

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

Outcome 4 – Individuals receive preventative care.											
Summary: None of the nine individuals reviewed received all of the preventative care they needed, although all had received some of what they needed. That said, based on interview with staff, there was an increased effort to catch up on preventive care, particularly off-campus appointments. For five of the nine individuals in the review group, 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. All of these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	Individual receives timely preventative care:										

	i. Immunizations	78% 7/9	1/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
	ii. Colorectal cancer screening	60% 3/5	1/1	N/A	0/1	1/1	N/A	1/1	N/A	0/1	N/A
	iii. Breast cancer screening	0% 0/2	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A
	iv. Vision screen	78% 7/9	1/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
	v. Hearing screen	11% 1/9	0/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1
	vi. Osteoporosis	29% 2/9	0/1	1/1	N/A	0/1	0/1	1/1	N/A	0/1	0/1
	vii. Cervical cancer screening	50% 1/2	N/A	N/A	N/A	1/1	N/A	0/1	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.	56% 5/9	1/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1

Comments: a. To determine whether or not IDTs followed the State Office-required process for determining whether or not individuals should attend community preventative care appointments, in a document request, the Monitoring Team specifically asked for: "For any preventative care not completed due to COVID-19 precautions, please provide the ISPA showing the IDT risk-benefit discussion." Center staff provided no documentation for any of the nine individuals in the review group.

The following provide examples of findings:

- For Individual #64:
  - On 2/17/20, he underwent his most recent audiological assessment. He was diagnosed with sensorineural hearing loss (SNHL), and the audiologist recommended bilateral hearing aids. However, the individual would not attend the appointment. The Center's Consultation Report was submitted, but the audiology consult was not submitted. There was no follow-up testing done, and the AMA did not provide a plan to address the individual's refusal to attend the hearing aid appointment. The AMA plan stated that follow-up testing was due in February 2021. According to the AMA physical exam, the individual's hearing was "grossly functional."
  - Based on medical staff report, he was scheduled for a DEXA scan in December 2021. He had several risk factors, including medication use and Vitamin D deficiency, making the screening overdue
- On 3/5/20, Individual #31 completed his last audiological assessment, with a recommendation to follow-up in one year. The next attempt did not occur until 10/18/21, and it was unsuccessful without sedation. Center staff reported no plan for another attempt with sedation.
- For Individual #51:

- The GI consult, completed on 12/11/17, included a recommendation to proceed with a colonoscopy as well as an EGD due to a "personal history of colon polyps and a family history of stomach cancer." According to the PCP, multiple attempts were made to have these studies completed, but the individual refused to attend the clinic. The documentation submitted did not show any attempts to complete a GI consultation in 2018. The first attempt without pre-treatment sedation (PTS) was on 12/17/19. On 2/10/20, and 3/20/20, two subsequent attempts with PTS occurred. Neither was successful. There was no documentation of additional attempts to have a follow-up colonoscopy for this individual with increased risk for colorectal cancer. The PCP stated the individual was scheduled for a GI appointment on 11/30/21.
- On 3/25/19, he completed his last vision assessment, with a recommendation to return in one year. The next attempt occurred on 9/20/21, but it was unsuccessful. He was rescheduled for 12/7/21.
- On 6/10/19, he completed his last audiological assessment, with a recommendation to return in one year. Multiple refusals were documented, and he was scheduled for an appointment on 11/22/21. His AMA stated that his hearing was intact, but the provider did not document the methodology for testing.

- For Individual #85:
  - On 4/17/19, she had her last breast cancer screening. Based on State Office policy, she was overdue for repeat screening (i.e., it was due one or two years after the April 2019 screening).
  - On 8/16/18, a DEXA scan indicated that she had osteoporosis of the left hip. She received no pharmacological treatment other than Vitamin D and calcium. She was overdue for follow-up. During interview, the Medical Director stated that it was scheduled for 11/30/21.
- For Individual #139:
  - The individual was diagnosed with congenital rubella syndrome. Following interview with the PCP, the Center submitted a vision exam, dated 10/8/15. This exam indicated that the individual could detect hand movement. According to the PCP, an eye evaluation was "scheduled last month," but the individual was uncooperative. The PCP indicated they were working with IDT on PTS. With no recent vision assessment, the Medical Director, who was the individual's PCP, was unsure if the individual had any vision.
  - This individual was diagnosed with hearing loss. Center staff submitted an audiology exam, dated 5/13/14, which documented: "This is an abnormal auditory threshold study suggesting impairment and auditory threshold perception on the left though ride [sic] side did appear to be present and intact down to 45 decibels." Under the discussion of preventive care, the AMA included a summary of an audiology assessment completed on 7/13/17. The summary stated that the individual had: "Sensorineural Hearing loss bilateral R>L." It was further stated that the PCP would discuss with the IDT the possibility of making the audiology follow-up PRN, or as needed. The assessment section of the AMA included different information in that it listed the last assessment as 5/13/14. The 2017 assessment was not discussed in this section. Again, the AMA stated that the PCP would discuss with the IDT the possibility of having only PRN assessments. During interview, when the PCP was asked about the individual's functional hearing and communication supports, the PCP responded that he believed communication was mostly through grunting and facial expressions. The PCP was not aware of a plan for follow-up testing.
  - The Medical Director was asked about the individual's risk for osteoporosis, and responded that the individual had Vitamin D deficiency and no medication risk. Therefore, no DEXA was performed. The preventive care section of the AMA stated that DEXA scanning was not indicated. However, the IRRF documented increased risk for osteoporosis due

to congenital rubella syndrome. Additionally, the IRRF stated: "He has had physical and lab evidence of testicular atrophy and gynecomastia and hypothyroidism as indications for suspecting secondary osteoporosis." The IRRF further documented that the individual had long-term treatment with oxcarbazepine, which has the potential to decrease bone mineral density.

- For Individual #114:
  - No documentation was found to show she received a second dose of the Shingrix vaccine.
  - On 3/7/19, she completed her last breast cancer screening. The PCP acknowledged the individual was overdue, but no repeat had yet been scheduled.
  - On 10/1/19, an audiological assessment showed the individual had a diagnosis of SNHL. The recommendation was to observe the individual clinically, and schedule a return visit in one year. The PCP reported an appointment was scheduled for 12/2/21.
  - On 2/10/20, the individual completed a well woman exam (WWE) without a pelvic exam. According to the gynecologist's note, the individual stated she would allow a pelvic exam to be done next year. The consultant recommended follow-up in one year, and also that individual have a mammogram. There was no documentation that she returned for the WWE and pelvic exam.
- For Individual #83:
  - In August 2021, the individual was admitted. He did not receive a number of needed vaccines until mid-November 2021. For example, he reportedly received the Hepatitis B vaccine on 11/4/21, the PSV23 vaccine on 11/13/21, and the HPV vaccine on 11/14/21. Center staff submitted a medication administration record (MAR) for the PSV23 vaccine, but they submitted no documentation for the Hepatitis B or the HPV vaccines. Tdap apparently was not administered.
  - On 11/4/21, he had cerumen removal under general anesthesia, but he had not yet had a hearing assessment completed.
- For Individual #77:
  - According to the AMA, on 3/10/21, the individual underwent a colonoscopy and the results were pending. During interview, the PCP stated that information was incorrect and no colonoscopy was done. On 12/1/21, the individual was scheduled to see the gastroenterologist for evaluation. There was no evidence that this 53 year-old male had ever had any screening for colorectal cancer.
  - On 9/24/19, he had his last audiological assessment, and was diagnosed with mild SNHL. The audiologist recommended conservative treatment with return in one year. The PCP reported failed attempts with PTS in September 2021, and on 10/14/21. No new appointment was scheduled.
  - He was diagnosed with osteopenia of the bilateral hips, but no DEXA report was submitted. According to the AMA, the last DEXA was done in May 2018, but no repeat DEXA was done. According to the PCP, he was due and "we are pending to schedule him."
- For Individual #59:
  - Based on staff report, on 9/9/21, he had cerumen impaction cleared, and on 10/5/21, he had auditory brainstem response (ABR) testing. However, no report was available to document this appointment. In the AMA, the provider only stated the individual responded to normal tone and volume.

- He was diagnosed with osteopenia. Staff reported that on 9/16/21, a repeat DEXA was done, but Center staff did not submit this report. They submitted the appointment form noting that the study was completed, but the report was not submitted.

b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable. In other words, the PCP should review the QDRR, provide an interpretation of the results, and discuss what changes can be made to medications based on this information, or state if the individual is clinically stable and changes are not indicated. PCPs had done this for five of the nine individuals.

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	64	31	51	85	139	114	83	77	59
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.											

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

Summary: Overall, as indicated in previous reports, the quality of medical practitioners' assessments of individuals with acute issues treated at the Center did not meet generally accepted standards of care. In most instances reviewed, PCPs also did not conduct proper follow-up of acute issues addressed at the Center. Some improvement was noted, though, with assessments prior to, as well as follow-up after individuals' returns from acute care settings. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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.	10% 1/10	0/2	0/1	N/A	0/1	1/2	N/A	0/1	0/1	0/2
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	10% 1/10	0/2	0/1		0/1	1/2		0/1	0/1	0/2

	status and the presenting problem until the acute problem resolves or stabilizes.										
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	100% 4/4	N/A	N/A	2/2	N/A	N/A	2/2	N/A	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 1/2			1/1			0/1			
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	50% 2/4			1/2			1/2			
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance, 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.	67% 2/3			1/2			1/1			
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.	50% 2/4			1/2			1/2			

Comments: a. For seven of the nine individuals in the review group, the Monitoring Team reviewed 10 acute illnesses/occurrences addressed at the Center, including: Individual #64 (upper respiratory infection on 5/9/21, and exacerbation of Parkinson's Disease on 10/4/21), Individual #31 (right 4th metatarsal fracture on 7/14/21), Individual #85 (chronic blepharitis on 6/9/21), Individual #139 (tinea corporis on 6/22/21, and tinea corporis and right elbow wound on 7/1/21), Individual #83 (deep tissue injury on 8/26/21), Individual #77 (rib contusion on 8/24/21), and Individual #59 (nasal fracture and laceration on 9/14/21, and fall with foot injury on 9/9/21).

a. and b. A PCP assessed the following acute issue according to accepted clinical practice, and conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized: Individual #139 (tinea corporis and right elbow wound on 7/1/21).

The following provide examples of concerns noted:

- On 5/9/21, at around 6:40 a.m., Individual #64 reported "I'm sick." Per nursing documentation, the individual coughed multiple times and sneezed. The nurse contacted the Advanced Practice Registered Nurse (APRN), who ordered COVID-19 and

flu testing. The individual was placed in quarantine, and the APRN ordered Robitussin. The APRN did not document any assessment.

On 5/10/21, nursing staff documented that the individual had no complaints. The nurse also documented that the colostomy bag was intact, but this individual had no history of a colostomy.

On 5/12/21, nursing staff documented that the individual returned home after his PCR test was negative. The PCP did not document any assessment, follow-up, or resolution for this illness.

- On 10/4/21, nursing staff documented that Individual #64 had excessive sweating and was shaking uncontrollably. Staff gave him water to drink, and noted that he stopped shaking and responded to questions.

  On 10/7/21, the PCP made a late entry for an assessment reportedly done at 8:00 a.m. on 10/5/21. According to PCP documentation, the individual was placed on the concerns list due to uncontrollable shaking and excessive sweating. The PCP's assessment was "Parkinson's Disease," and the plan was to order labs and perform vital sign assessments every four hours for 24 hours. Based on the documentation submitted, it was not clear that the PCP saw the individual, and if so, when the physical assessment occurred.

  On 10/7/21, at approximately 10:45 a.m., the PCP documented contacting the neurology consultant's office with regard to increasing the dose of Sinemet due to an intensification of the individual's symptoms. The PCP wrote that the neurologist: "did mention in previous consult notes back in August 2021, that he wanted to titrate Sinemet due to [the individual's] resting tremors, but no instructions or indications were received. After speaking with office Rep… today, there was [sic] recommendations written back in August from the PA [Physician's Assistant] to increase Sinemet to TID [three times daily]. These recs were never received at clinic." This PCP statement underscored the significant problems the Center experienced with the tracking of consultations and recommendations. This delay impacted the care of the individual. The PCP was aware of the consultant's recommendation to titrate the Sinemet, but made no attempts to contact the neurology office to obtain a specific medication titration plan. The individual clearly was experiencing increased symptoms and the failure to clarify the recommendations resulted in a two-month delay in adjusting the medication regimen.

  After review of the recommendations, the plan was to increase the Sinemet dose. Follow-up was to occur in four days, but as of the time of the document request submission on 10/15/21, there was no documentation that follow-up occurred.

- On 7/14/21, at around 9:40 a.m., nursing staff documented that at 7:02 a.m., Individual #31 was limping. Examination of the right foot was pertinent for swelling and redness. The nurse notified the medical provider, and documented that "MD will check the client." At 2:30 p.m., nursing staff notified the Medical Director that the individual continued to limp and needed evaluation. Per nursing documentation: "he ordered the nurses to observe on it first and he will check him up [sic] tomorrow."

  On 7/15/21, the Medical Director wrote: "Notified at morning medical meeting that nurses requested clinic physician to see client due to report of R foot swelling, and limping gait." As noted above, nursing staff documented that on 7/14/21, the Medical Director was notified that the individual needed evaluation. The Medical Director documented a physical exam of the

head, neck, heart, and lungs, but stated the individual did not allow an exam of the lower extremity. According to nursing documentation, the individual was checked in the lobby. The plan was to obtain x-rays.

On 7/16/21, the PCP documented that the individual had a fracture of the 4th metatarsal. Habilitation Therapy staff recommended the use of an ace bandage, and limited weight bearing. Orthopedics was consulted. Based on documentation submitted, no medical provider conducted a reassessment to document the motor and neurovascular status of the extremity.

On 7/28/21, the PCP documented the results of the orthopedic consult, completed on 7/19/21. The Center did not submit the orthopedics consult as requested. There was no further medical provider documentation related to the foot fracture.

On 10/6/21, the locum PCP documented: "Was reviewing his list of consults yesterday. Attempted FU visit with Ortho was unsuccessful. Ordered repeat R foot XR since >2 months since R 4th metatarsal fx discovered on 7/15/21." The x-ray revealed a healing fracture. The plan was to repeat the x-ray in six to eight weeks to check for union, if the PCP agreed.

- On 6/9/21, Individual #85's PCP made an IPN entry related to an assessment that was done on 6/8/21. The PCP indicated that the individual was discussed in "morning medical meeting yesterday regarding her red eyelids and eyes." There was no information documented relative to the length of the individual's symptoms, previous evaluations, or treatments. The exam was pertinent for "reddish conjunctiva and right eyelid dryness, crusting and redness." The PCP documented a three-line assessment and plan. This assessment and plan was identical to that found in the 4/26/21ophthalmology consult IPN. The second item was "Cataracts OU- MODERATE, No treatment recommended as of yet." This might have been relevant for the ophthalmology consult, but it was not relevant to the acute eye issue. It appeared the PCP just repeated an old assessment and plan. Given that the previous plan did not appear effective, it was not clear why the Medical Director made no changes to the plan, and did not document a plan for PCP or ophthalmology follow-up.

  On 6/30/21, the locum PCP saw the individual due to the same complaint. A decision was made to make no medication changes, but the locum PCP noted that an earlier follow-up would be scheduled with ophthalmology to determine if other recommendations were needed. Follow-up was scheduled for one week. On 7/2/21, the locum PCP documented that the culture and sensitivity of the eye discharge showed rare gram-positive cocci, and the PCP would see the individual the following week. The PCP did not document a follow-up assessment in one week. However, on 7/9/21, the PCP documented the results of a follow-up ophthalmology consult that was completed on 7/6/21. The recommendations were to wear an eye mask at night, and provide treatment for blepharitis and dry eyes. There was no specific follow-up for the condition.

  On 7/27/21, the PCP documented a post-ED follow-up related to a dislodged enteral tube. The physical exam noted reddish conjunctiva. The assessment and plan did not address this abnormal eye finding.
- On 6/18/21, nursing staff documented that Individual #139 had two circular red patches on his right thigh. The nurse notified the Medical Director.

  On 6/22/21, the Medical Director documented that nursing staff reported the individual had round lesions on his right thigh. The assessment date reportedly was 6/18/21. The skin exam was pertinent for: "two-coin sized lesions on the anterior aspect of the right thigh." The PCP made the diagnosis of tinea corporis, but did not provide any evidence to support the diagnosis.

That is, the provider documented none of the characteristics of tinea corporis, such as pruritis, erythema, or hyperpigmentation. Tinea corporis is frequently scaling or plaque-like, and spreads centrifugally. It characteristically may result in an annular or ring-shaped plaque.

The PCP's plan was to apply clotrimazole for two weeks and follow-up prn.

- On 8/26/21, nursing staff documented that Individual #83 was walking funny. Upon examination of the left foot, the nurse discovered a 2.5-centimeter (cm) blood filled blister of the heel.

  On 8/27/21, the PCP evaluated the individual. The PCP documented for the subjective complaint that the individual was "nonverbal." The subjective complaint should be the complaint of the individual or the reason that nursing staff referred the individual for evaluation. Per IPN documentation, the individual reportedly was limping and walking barefoot the day prior to evaluation. The PCP's assessment was "purple discoloration on left heel, possible deep tissue injury vs. blood blister about 2cm in diameter." There was no discussion related to the etiology of the injury, or how to provide pressure relief. The plan was to keep the area clean and dry, and open to air. The PCP prescribed acetaminophen for pain, but documented no plan for follow-up.

  On 9/1/21, another PCP documented: "Left heel noted with purple discoloration, previous blood/friction blister no longer noted, skin appears moist, no discharge, redness or swelling, area is tender to touch as client pulled foot away while assessing." Again, the assessment was deep tissue injury of the left heel, but the provider made no referral to a wound care center or podiatry for further evaluation. The plan was to apply DuoDerm every seven days and as needed, and follow-up next week. There was no documentation of follow-up the next week.

  On 10/13/21, the PCP documented that the left heel had a 1cm-by-1cm friction wound with a small area of eschar tissue. At this time, the individual was referred to podiatry.
- On 8/24/21, nursing staff documented that Individual #77 had redness and swelling of the right rib cage. This was possibly related to a behavioral episode that occurred on 8/23/21.

  On 8/26/21, the PCP documented: "As per EP [home] charge nurse client with bruising to right and left rib cage area and swelling." While the note was dated 8/26/21, the PCP documented the assessment date as 8/24/21. The PCP provided no information regarding the possible etiology of the abnormality. The PCP further noted that the individual was sitting in his wheelchair calm, awake, and alert, but he refused to go inside for an assessment. Mild bruising was noted to the bilateral ribs and the right lower ribs had "slight protrusion/rib flair." The PCP's assessment was "bruising/contusion to bilateral ribs." The plan was to obtain rib films. The x-rays showed no fracture. However, the PCP documented what appeared to be a recommendation from the radiologist: "Recommendation-Non-displaced rib fractures may be radiographically occult in the acute state, and the need for repeat evaluation in 10-14 days should be determined clinically." Notwithstanding this radiology recommendation, the PCP's plan was limited to "Follow-up as needed." There was no plan to re-evaluate the individual.
- On 9/14/21, nursing staff documented that Individual #59 banged his face on a plexiglass window, resulting in a laceration to his nose. On 9/14/21, the PCP documented: "As per charge nurse, client with laceration to nose due to SIB [self-injurious behavior]." The PCP did not provide any information on the type of SIB or mechanism of the injury. The nasal exam was

pertinent for a 2-cm laceration on the bridge of the nose. There was mild swelling and bleeding noted. The PCP did not document the important examination of the nasal septum, or document the presence or absence of a septal hematoma. The wound was cleaned and closed with Dermabond. The PCP prescribed acetaminophen, and ordered an x-ray to rule out a nasal fracture.

On 9/15/21, the PCP documented that the individual had an acute nasal fracture. The PCP documented that there was no nasal hematoma, but did not specifically state that there was no septal hematoma. The plan was to follow-up with ear, nose, and throat (ENT) the next day.

On 9/16/21, ENT evaluated the individual. The otolaryngologist noted that the individual had an acute nasal fracture that was not affecting his breathing. He further stated: "I do not see any septal hematomas, everything looks good."

On 9/27/21, the PCP conducted follow-up for the nasal fracture and left foot injury. With regard to the nasal fracture, the PCP noted that there was mild redness, tenderness, and no hematoma. The laceration remained approximated. There was no specific plan for the nasal injury which was not fully resolved. The PCP indicated follow-up would occur PRN.

- On 9/8/21, nursing staff documented that Individual #59 fell at 8:30 a.m., and was limping after the fall. The nurse notified the PCP, who ordered x-rays.

  On 9/9/21, the PCP documented an assessment for the individual related to "pain, swelling and not bearing weight to left foot." According to the IPN entry, the assessment date was 9/8/21. The PCP did not document the mechanism of the injury. It would be important for the PCP to understand if the individual twisted his ankle, fell, or had some other type of injury. It would also be important for the PCP to note whether or not the individual was able to bear weight immediately after the injury.

  The PCP documented an examination of the foot that was pertinent for moderate swelling to the dorsal lateral foot. The PCP reported that the pedal pulses were strong. There was "full ROM [range of motion] to both legs bilaterally." The PCP did not specifically document an examination of the ankle, noting the presence or absence of tenderness at the medial and lateral malleoli. The PCP also did not document the presence or absence of ligamentous laxity, which would be important in establishing the diagnosis of an ankle injury. The PCP's plan was to apply an ace wrap, offer a wheelchair, and x-ray the left foot and ankle.

  In the 9/9/21 IPN entry, the PCP documented that x-rays were negative for an acute fracture, but showed lateral soft tissue swelling and degenerative changes in the foot consistent with mild osteoarthritis. The PCP did not provide a diagnosis, and there was no specific plan of care after the x-rays were done. On 9/15/21, the PCP documented the left foot pain was resolved.

c. through e., g., and h. For two of the nine individuals reviewed, the Monitoring Team reviewed four acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #51 (hospitalization for loss of consciousness on 7/3/21, and ED visit for seizures on 8/24/21), and Individual #114 (hospitalization for foreign body ingestion on 7/5/21, and ED visit for foreign body ingestion on 8/6/21).

The following provide examples of the findings for these acute events:

- According to nursing documentation, on 7/3/21, staff found Individual #51 outside on the ground, unconscious. The writer explained that it was not known if the individual hit his head, fainted, or had a seizure. Staff administered cardiopulmonary resuscitation (CPR) before the individual regained consciousness. Emergency Medical Services (EMS) was activated. It was concerning that the nursing staff documentation indicated that at one point after these events, the individual was sitting in his wheelchair. The individual was found on the ground with possible trauma and a head injury, and should have had stabilization of his cervical spine.

  On 7/5/21, the PCP documented a transfer note stating the individual was sent to the hospital on 7/3/21, due to closed head trauma with a loss of consciousness. This was an after-hours transfer with a note within one business day.

  Per ED documentation, the individual was found unresponsive on the ground with agonal breathing. "Staff started CPR without checking a pulse and after 20 minutes of CPR patient was stable."

  On 7/5/21, the individual returned to the Center, and on 7/6/21, a PCP saw him. The PCP documented that the discharge diagnoses were breakthrough seizures, and closed head trauma with loss of consciousness. There was no documentation of treatment in the hospital.

  On 7/7/21, the PCP documented that during the hospitalization, the individual was diagnosed with breakthrough seizures and was started on Keppra. A non-contrast computed tomography (CT) scan of the head was negative. The plan was to follow the hospital discharge recommendations, follow up with the neurologist in one week, and schedule an EEG. The PCP did not outline the hospital recommendations in the post -hospital IPN. Follow-up was intended to occur "in 1 week and or as needed." There was no documentation of follow-up in one week in the records submitted. At the time of the review in November 2021, the individual had not had a neurology consultation or an EEG.

  On 7/9/21, the IDT held an ISPA meeting, and clarified the events leading up to the ED visit, stating that the individual fell forward from his wheelchair, hit his head, and lost consciousness. The direct support professional (DSP) immediately started compressions on him. There was no discussion about whether starting CPR was appropriate (i.e., did the DSP check for a pulse?). No medical provider attended the ISPA meeting.
- On 8/25/21, the PCP documented that on 8/24/21, at 1:15 p.m., Individual #51 was transferred to the ED for evaluation of breakthrough seizures. The PCP wrote: "At around 1210 NP charge nurse called to report client was having what seemed like periodic seizure like activity since earlier today but now has been more consistent x 5 minutes. At no point has client lost consciousness but has been observed with twitching of both arms and unusual head movements."

  The PCP assessed the individual. The PCP reported that the date of the assessment was 8/24/21. According to the PCP, the individual was "assessed/observed" in the hallway at 12:12 p.m. The PCP sated the individual was awake, alert, and oriented, but there was no documentation of a physical exam.

The plan stated: Orders: 12:30 - "Recommend client to be placed on 1:1 supervision until the IDT meets for medical safety. Stat Lamotrigine Level, and Ativan 1mg IM x 1 dose now." The PCP documented that at 12:40 p.m., the decision was made to send the individual to the hospital for breakthrough seizures.

Per nursing documentation on 8/24/21, "seizure was started at 12:05 and lasted 5 mins and client is conscious and responsive already." The nurse noted that the "client is still having twitching of arms even after the seizure." Nursing staff documented that at 12:30 p.m., the individual "started to have seizures again."

This individual was evaluated in the ED, and returned to the Center at around 9:35 p.m. The PCP documented that the post-ED assessment date was 8/25/21. However, the date for the IPN documentation was 8/31/21, which was seven days after the individual returned to the Center. According to PCP documentation, the individual was diagnosed with breakthrough seizures and hypokalemia. However, based on nursing documentation, this individual seized for five minutes and never fully recovered prior to the next seizure. By definition, the individual experienced status epilepticus. Moreover, the individual continued to have twitching after the seizure and prior to having the second seizure, which resulted in transfer to the ED. The PCP documented that attempts to have follow-up with neurology were not successful due to the individual's refusal, and the plan included having the IDT meet for appointment supports.

On 8/28/21, the PCP made an IPN entry documenting an assessment that they reportedly completed on 8/26/21. The assessment was breakthrough seizures. The plan included obtaining labs, an EEG, and neurology appointment. At the time of the Monitoring Team's review, nether the EEG nor the neurology appointment had been completed. The Center did not submit the admission history and physical, discharge note, or a neurology consult for this admission.

During the Monitoring Team's 2018 review, morning medical meeting discussion identified that an individual had status epilepticus that was not appropriately identified. This resulted in the Quality Assurance (QA) nurse initiating a discussion related to the management of status epilepticus. The outcome of the discussion was that the Center did not follow appropriate clinical guidelines for the management of status epilepticus. It is concerning that the identification and management of status epilepticus appears to remain challenging.

- On 7/5/21, nursing staff documented that Individual #114 reported swallowing a bottle cap. The nurse notified the Medical Director. No new orders were given. The plan was to monitor.

  On 7/6/21, nursing staff documented that the individual experienced vomiting while eating breakfast. She was placed on the lung assessment protocol. At around 5:30 p.m., per nursing documentation, the individual was coughing during dinner and appeared to be attempting to clear her throat. It was noted that she could not "swallow anything without immediately coughing it up." The medical provider gave a one-time order for IM Zofran.

  On 7/7/21, nursing staff again notified the PCP that the individual experienced emesis during breakfast. Again on 7/8/21, nursing staff documented emesis.

On 7/8/21, the SLP conducted a mealtime evaluation and noted that the individual coughed after several bites, and showed some distress. The individual was then scheduled for an MBSS. The PCP was notified multiple times over the three-day period that the individual was experiencing a cough, difficulty swallowing, and had multiple episodes of emesis. The PCP did not conduct an evaluation. Given the individual's history of reporting swallowing a bottle cap and the timing of the onset of emesis, it was not clear why an x-ray was not performed to rule out the presence of a foreign body.

On 7/8/21, the Medical Director documented for the subjective complaint: "I was informed that the patient needs assessment after being reported that the client tried to swallow a bottle cap as well as having nausea and vomiting episodes. When I went to examine client she did not have any signs of distress or asphyxia." The assessment was "Foreign Body Ingestion, questionable attempt and Nausea and Vomiting." The plan was to monitor closely and implement the IDT recommendations. The provider signed the MBSS order. The individual continued to have reports of difficulty swallowing.

On 7/14/21, a MBSS was done and showed a foreign body in the individual's esophagus, possibly a water bottle cap. On 7/15/21, the Medical Director documented that the individual was referred to the ED for possible extraction of a foreign body.

At 10:15 p.m., she returned to the Center, and on 7/16/21, the PCP saw her. According to PCP documentation, x-rays and a CT scan were negative for foreign bodies. The plan was to refer the individual to GI and continue the recommendations of the SLP.

- On 8/6/21, nursing staff documented that the DSP reported that Individual #114 "swallowed a bingo chip in the lobby." The nurse notified the Medical Director, who ordered a KUB. Per nursing documentation, "as per radiologist, findings are not significantly different form her last KUB on 6/14/21."

On 8/9/21, the Medical Director made an IPN entry stating that on 8/7/21, the individual was transferred to the ED due to "dysphagia." Per PCP documentation: "I was called by the nurse that [the individual] has been having difficulty swallowing and pain early Saturday morning." This was an after-hours transfer with a note written within one business day.

On 8/7/21, the individual returned to the Center, but it was not until 8/9/21, that the PCP saw her. Per State Office Medical Policy: "When an individual is readmitted to an SSLC following an ER visit or hospitalization: A PCP must examine the individual within 24 hours, summarize the events of the ER visit or hospitalization, surgeries, and any special procedures (e.g., scans, lab tests, etc.)."

On 8/9/21, the Medical Director documented a post-ED note that indicated that the individual underwent extraction of a foreign body via EGD. She also was diagnosed with distal esophagitis. The plan was to treat with omeprazole for eight weeks. The Medical Director did not discuss the supports related to prevention of pica.

On 8/20/21, the individual was referred again to the ED for another foreign body ingestion.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: For four of the 13 non-facility consultations reviewed, Center staff did not submit the reports from the consultants. An additional three reports arrived	Individuals:

more than two weeks after the appointments. It was not clear what efforts staff made to obtain the reports sooner. Efforts are needed to improve the Center's system for tracking consultation reports and recommendations.											
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	69% 9/13	0/2	1/2	1/1	0/1	N/A	2/2	1/1	2/2	2/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	46% 6/13	0/2	1/2	1/1	0/1		2/2	1/1	0/2	1/2
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.	69% 9/13	0/2	1/2	1/1	0/1		2/2	1/1	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.	100% 2/2	N/A	N/A	N/A	N/A		N/A	1/1	1/1	N/A

Comments: For eight of the nine individuals in the review group, the Monitoring Team reviewed a total of 13 consultations. The consultations reviewed included those for Individual #64 for neurology on 8/23/21, and hematology on 7/26/21; Individual #31 – neurology on 8/2/21, and ophthalmology on 8/30/21; Individual #51 – endocrinology on 6/28/21; Individual #85 – ophthalmology on 7/6/21; Individual #114 – gastroenterology (GI) on 8/13/21, and GI on 7/16/21; Individual #83 – ENT on 9/23/21; Individual #77 – neurology on 6/4/21, and ophthalmology on 6/17/21; and Individual #59 – ENT on 9/16/21, and ophthalmology on 6/8/21.

a. through e. For the following consultations, Center staff did not submit the consultation reports: Individual #64 for neurology on 8/23/21, and hematology on 7/26/21; Individual #31 – neurology on 8/2/21; and Individual #85 – ophthalmology on 7/6/21. As a result, it was not possible to confirm whether or not PCPs responded to them timely and appropriately.

Of note, on 10/7/21, at 10:45 a.m., Individual #64's PCP documented contacting the neurology consultant's office with regard to increasing the dose of Sinemet due to an intensification of the individual's symptoms. The PCP wrote that the neurologist: "did mention in previous consult notes back in August 2021, that he wanted to titrate Sinemet due to [the individual's] resting tremors, but no instructions or indications were received. After speaking with office Rep… today, there was [sic] recommendations written back in August from the PA [Physician's Assistant] to increase Sinemet to TID [three times daily]. These recs were never received at clinic." This PCP statement underscored the significant problems the Center experienced with the tracking of consultations and recommendations. This delay impacted the care of the individual. The PCP was aware of the consultant's recommendation to titrate the Sinemet, but made no attempts to contact the neurology office to obtain a specific medication titration plan. The individual clearly

was experiencing increased symptoms and the failure to clarify the recommendations resulted in a two-month delay in adjusting the medication regimen.

Three consultation reports in the sample reviewed arrived more than two weeks after the appointments. As indicated in the medical audit tool: "If consultant reports are not received within two weeks, or sooner if clinically indicated, documentation should show the Facility's efforts to obtain them." For the following consultations, it was not clear what efforts staff made to obtain them sooner: Individual #77 – neurology on 6/4/21 (i.e., received 6/30/21), and ophthalmology on 6/17/21 (i.e., received 7/26/21); and Individual #59 – ENT on 9/16/21 (i.e., received 10/1/21).

For the remaining consultation reports reviewed, PCPs indicated agreement or disagreement with the recommendations timely, and provided rationales for disagreements. The PCP IPNs related to the remaining consultations included all of the components State Office policy requires.

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

Summary: Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For four of the 18 chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and identified the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.

Individuals:

#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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.	22% 4/18	1/2	1/2	0/2	1/2	0/2	0/2	1/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #64 – GI problems, and hypothyroidism; Individual #31 – macrocytic anemia, and constipation/bowel obstruction; Individual #51 – history of colon polyps, and seizures; Individual #85 – constipation/bowel obstruction, and B12 deficiency; Individual #139 –SNHL, and Vitamin D deficiency; Individual #114 – GI problems, and cardiac disease; Individual #83 – Vitamin D deficiency, and unspecified anemia; Individual #77 – adrenal insufficiency, and osteoporosis; and Individual #59 – hypertension, and osteoporosis).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #64 – hypothyroidism, Individual #31 – constipation/bowel obstruction, Individual #85 – constipation/bowel obstruction, and Individual #83 – Vitamin D deficiency.

The following provide examples of concerns noted:

- On 9/27/18, Individual #64 underwent a GI consult, and the recommendation was to perform a colonoscopy for colorectal cancer (CRC) screening in this 54-year-old male. The gastroenterologist also recommended that the individual have an esophagogastroduodenoscopy (EGD). The Center submitted no documentation to show that these studies were performed after the recommendations were made.

  During interview, the PCP reported that prior to 2020, there was no documentation of CRC screening [i.e., colonoscopy or fecal immunochemical test (FIT)]. This was consistent with the 2019 AMA, which did not document evidence of CRC screening, but stated that the plan was to perform FIT testing.

  In February 2020, the individual eventually had CRC screening done, which was seven years after this cancer screening was due (i.e., the individual was now 57 years old). The colonoscopy showed a 2.5-cm polyp. Due to the risk of colonic perforation related to the large size of the polyp, it was not removed. The individual was referred for evaluation for surgical intervention. There was no documentation that a surgical evaluation was completed. Staff reported that the surgery evaluation did not occur due to COVID-19 restrictions. However, there was no documentation to show that the IDT followed the State Office guidelines for conducting a risk/benefit analysis related to sending the individual out for community appointments.

  On 3/10/21, a repeat colonoscopy was performed, and the individual was diagnosed with a 5-cm ileocecal mass. On 3/11/21, the individual had a surgical evaluation, and the plan was to proceed with cardiac clearance. On 10/19/21, the individual underwent a right hemicolectomy.

  According to the Medical Director, the legally authorized representative (LAR) was reluctant to proceed with surgery. However, the ISPA, dated 6/17/21, only stated that the LAR/sister "had questions about the type of surgery." The ISPA further documented that: "The PCP answered her questions and informed her that [Individual #64] would stay in the hospital until he has recovered. Surgery was agreed upon."
- According to the AMA, Individual #31 was diagnosed with macrocytic anemia that was treated with Vitamin B12, folate, and ferrous sulfate. The assessment section documented that a hematologist evaluated the individual "who advised this regimen." The documents reviewed did not include any hematology consultations. However, the AMA provided summaries of the most recent hematology consultations. Several of these summaries noted that the individual "could benefit from daily folic acid 1mg daily and Vitamin B12 1000mcg daily." None of the summaries stated that the individual should receive ferrous sulfate. The AMA plan was to continue B12, folate, and iron supplementation, and monitor the individual's complete blood count (CBC), iron, B12, and folate levels.

  During interview, the Medical Director was asked if there was documentation to support the use of iron for this individual, or if the individual had documented iron-deficiency. The Medical Director responded that the individual was scheduled for a hematology consult on 12/2/21.
- For Individual #51, the GI consult, completed on 12/11/17, included a recommendation to proceed with a colonoscopy as well as an EGD due to a "personal history of colon polyps and a family history of stomach cancer." According to the PCP, multiple attempts were made to have these studies completed, but the individual refused to attend the clinic. The documentation submitted did not show any attempts to complete a GI consultation in 2018. The first attempt without pre-treatment sedation

(PTS) was on 12/17/19. On 2/10/20, and 3/20/20, two subsequent attempts with PTS occurred. Neither was successful. There was no documentation of additional attempts to have a follow-up colonoscopy for this individual with increased risk for colorectal cancer. The PCP stated the individual was scheduled for a GI appointment on 11/30/21.

According to the IRRF, the individual had two failed attempts to complete a colonoscopy. The IRRF did not provide the dates. Per IRRF documentation, the individual was cooperative with the bowel preparation, but standard and high-dose preps did not result in adequate cleansing. He was rated at medium risk for GI problems.

- According to the AMA, Individual #51 was diagnosed with a seizure disorder. The seizure classification was not noted in the assessment section of the AMA. The assessment and plan was a two-line statement. The individual was prescribed lamotrigine for seizure control and reportedly saw the neurologist annually. The last appointment was in April 2019.

  During interview, the PCP reported that the date of the individual's last seizure was not known. This was clarified later with information that in August 2021, breakthrough seizures were recorded. The PCP stated that attempts to have neurology follow-up and complete an EEG were not successful. The PCP could not provide a specific plan regarding what was done to address the breakthrough seizures.

  Per the restraint plan, dated 12/10/20, the neurology appointment on 4/2/19 was successful with PTS. The plan did not list any subsequent attempts for neurology appointments. Center staff did not submit any documentation of attempts to obtain an EEG.

  In July 2021, the individual was hospitalized for breakthrough seizures. In August 2021, the individual also met the criteria for status epilepticus.
- Individual #85 was diagnosed with B12 deficiency. The PCP documented that she was treated with a healthy diet and daily B12 supplementation. There was no discussion of the etiology of the B12 deficiency. There was no documentation of the individual's response to treatment. That is, the PCP did not document the response to treatment by noting the most recent CBC values. The plan was to monitor with a CBC and B12 levels every six months.
- Individual #139 was diagnosed with hearing loss. Center staff submitted an audiology exam, dated 5/13/14, which documented: "This is an abnormal auditory threshold study suggesting impairment and auditory threshold perception on the left though ride [sic] side did appear to be present and intact down to 45 decibels."

  Under the discussion of preventive care, the AMA included a summary of an audiology assessment completed on 7/13/17. The summary stated that the individual had: "Sensorineural Hearing loss bilateral R>L." It was further stated that the PCP would discuss with the IDT the possibility of making the audiology follow-up PRN, or as needed.

  The assessment section of the AMA included different information in that it listed the last assessment as 5/13/14. The 2017 assessment was not discussed in this section. Again, the AMA stated that the PCP would discuss with the IDT the possibility of having only PRN assessments. During interview, when the PCP was asked about the individual's functional hearing and communication supports, the PCP responded that he believed communication was mostly through grunting and facial expressions. The PCP was not aware of a plan for follow-up testing.

- Individual #139 was diagnosed with Vitamin D deficiency that was treated with a combination calcium/Vitamin D tablet as well as cholecalciferol. At the time of the AMA, the last Vitamin D level was done on 6/20/20, and it was 69. A repeat Vitamin D was done on 7/7/21, and was 75. Neither of these levels was consistent with the recommended range stated in the State Office osteoporosis guidelines, which require written justification when the provider makes a decision to maintain a Vitamin D level above 50. No PCP IPN documentation was found related to the level of 75 to indicate that a change in therapy was made, or to provide justification for maintaining a level over 50.

  It also should be noted that in addition to Vitamin D deficiency, the IRRF outlined multiple risk factors for osteoporosis including hypogonadism and long-term anti-epileptic drug (AED) use. The IRRF indicted that DEXA scanning was needed, but the AMA discussion of the risk for osteoporosis noted that DEXA scanning was not needed.
- During a colonoscopy on 8/13/21, Individual #114 was diagnosed with colon polyps. During interview, the Medical Director reported that the repeat colonoscopy was scheduled to occur in three years. However, the Medical Director went on to describe that multiple polyps were removed, including hyperplastic, serrated adenomas, and a tubulovillous adenoma. The Medical Director should have questioned this plan, given that a three-year follow-up would not be consistent with accepted practice for the number and types of polyps removed. The Center did not submit the follow-up GI consult. However, the IMR, which the locums physician completed, documented that the GI consult, done on 8/23/21, stated follow-up needed to occur in one year.

  On 9/16/21, the Medical Director also made an IPN entry stating that the GI consult on 8/23/21, made the recommendation to follow-up in one year. Since the IMR, completed on 9/22/21, included a list of active problems and plans of care to the address the active problems, the physician/PCP should have added colon polyps as an active problem. The need for a repeat colonoscopy in one year should have been included in the plan.
- Individual #114 was diagnosed with congestive heart failure (CHF) and hypertension. In the AMA, the two were discussed in a single paragraph, which made the assessment and plan for each difficult to understand. According to the assessment, the individual's CHF was compensated and stable. She was treated with Coreg, losartan, and Entresto. According to the AMA, the most recent cardiology consult was done on 2/4/20, and the plan was to continue Coreg and losartan. The assessment and plan section of the AMA stated: "will seek cardiology consult if she is symptomatic." It was not clear why the locum physician did not believe the individual required routine follow-up.

  At the time of the review, the individual's medication regimen included Coreg, losartan, and Entresto. Thus, the individual was treated with two angiotensin receptor blockers (ARBs). Therapeutic duplication of this type is not generally recommended. The Medical Director, who is a cardiologist, served as the PCP for this individual. During interview, he was asked the rationale for the use of two ARBs. He reported that he considered this to be inappropriate therapy, and recognized it was an issue, but had not had the time to make the adjustments. He also was reluctant to make any adjustments to the medication regimen due to the individual's issues with pica. It was not clear how pica influenced the management of her CHF. He also reported that the individual had episodes of hypotension in April and May. He reported that the day prior to the interview, he reviewed the individual's record, and made the decision to address the issue of therapeutic duplication. On 11/18/21, during the week of the remote review, medical staff reported in the morning medical meeting that changes were made in the medication regimen. The losartan was discontinued and the dose of Entresto was increased.

- The AMA noted that Individual #83 had an unspecified anemia that was possibly caused by psychotropic medications. The iron panel was reported as within normal limits (WNL), and the plan was to order a Vitamin B12 level. At the time of the review, his anemia was treated with ascorbic acid and multivitamin supplementation.

  Over the course of several reviews, the Monitoring Team has documented that PCPs at Rio Grande State Center were not following current algorithms for the evaluation and management of anemia. Of further concern, PCPs often made the decision to treat individuals diagnosed with anemia with a combination of B12, folate, and ferrous sulfate prior to obtaining a thorough laboratory evaluation.

  Algorithms are readily available to assist clinicians in the evaluation of anemia. The basic evaluation of anemia includes the review of the individual's history, documentation of symptoms of anemia, a physical exam, and laboratory testing. Testing should include a CBC with platelets, red blood cell (RBC) indices and morphology, reticulocyte count, and review of the peripheral smear. Additional testing is done based on the results of the basic testing, and the suspected cause of the anemia. There was no evidence to support that the PCP conducted a proper evaluation of the anemia for this individual.
- Individual #77 was diagnosed with adrenal insufficiency. During interview, the PCP was asked about the etiology of the adrenal failure and how the diagnosis was made. The PCP responded: "I don't have an answer for that." It was reported that an endocrinologist managed the adrenal insufficiency.

  Center staff submitted an endocrine consult, dated 11/9/21, that stated: "Patient with ? adrenal insufficiency. Recommend to continue hydrocortisone 15me qAM and 5mg qPM. Unknown source of diagnosis. Will check ACTH and cortisol level. Ideal test is the Cosyntropin stim test but test cannot be performed at this time because patient is on chronic hydrocortisone. Recommend to double the dose in case of acute illness/stress."

  The PCP also was asked if the IDT was educated on the diagnosis of adrenal insufficiency, and the need to recognize early minor illnesses and stress so that adjustments in hydrocortisone could be made. There was no evidence that the IDT and staff had received the necessary training.
- According to the preventive care section of Individual #77's AMA, a May 2018 DEXA scan showed osteopenia of the hips. Center staff did not submit a copy of the DEXA report, stating it was "Not applicable." Osteopenia was not listed as an active problem. Therefore, there was no plan to address this active medical problem.

  The individual was treated with calcium and Vitamin D. During interview, the PCP acknowledged that no fracture risk assessment was calculated to determine if additional treatment was warranted. There also was no repeat DEXA performed. The PCP reported that "we are pending scheduling him."
- According to the AMA, Individual #59 was diagnosed with hypertension that was managed with Norvasc. He also had a diagnosis of aortic regurgitation, and an abnormal electrocardiogram (EKG). He was followed by cardiology. In August 2019, the last cardiology evaluation was completed and follow-up was on hold due to COVID-19 precautions. The goal was to maintain the blood pressure "WNL," but the PCP did not specify a target blood pressure.

During interview, the PCP was asked if there was evidence of target organ damage since there was no discussion of this in the AMA. The PCP responded that that information would be included in the next AMA. Moreover, at the time of the interview, the cardiology appointment was "pending."

- The PCP documented in the AMA assessment section that on 5/15/20, Individual #59 had a DEXA scan that showed bilateral hip osteopenia. However, the preventive care section of the AMA stated that the last DEXA was done in May 2018, and the repeat was not obtained in 2020 due to pandemic precautions. The IRRF also stated that the last DEXA was obtained in 2018. Center staff did not submit documentation for any DEXA scans.

  The treatment regimen for the individual included weekly Alendronate, and daily calcium and Vitamin D.

  During interview, the PCP stated that on 9/16/21, a DEXA was done and the results showed "osteoporosis consistent with a higher fracture risk." When asked if the progression from osteopenia to osteoporosis, which reflected a poor response to therapy, resulted in any change in the medical plan of care, the PCP responded that "we have not changed it as of yet."

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. For 14 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. However, for three of the four remaining IHCPs reviewed, documentation was found to show implementation of those few action steps that IDTs had assigned to PCPs and included in IHCPs/ISPs. Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	75% 3/4	N/A	N/A	1/1	N/A	0/1	2/2	N/A	N/A	N/A

Comments: a. As noted above, none of the 18 IHCPs reviewed included a full set of action steps to address individuals' medical needs. For 14 of the chronic conditions/risk areas reviewed, either no IHCP existed or the IDT assigned no interventions to the PCP. However, the action steps assigned to the PCPs were implemented for the following: Individual #51 – seizures (i.e., schedule neurology appointment as soon as it can be, and write orders for labs every three months), and Individual #114 – GI problems (i.e., continue supports for constipation; colonoscopy every three years as recommended by GI to follow-up "gastric [sic] polyp"), and cardiac disease (i.e., continue medication supports for hypertension and congestive heart failure; labs; prn cardiology assessments).

Due to ongoing problems with the quality of the medical plans included in IHCPs, this indicator did not provide an accurate picture of whether or not PCPs implemented necessary interventions.

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	64	31	51	85	139	114	83	77	59
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: a. and b. Due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate these indicators.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.	
Summary: For the nine individuals in the review group, three of 17 QDRRs were completed timely. At the time of the last review, problems also were noted with timeliness, and the Monitor recommended that staff put procedures in place to correct the problems. Given that the problem worsened, Indicator a will return to active oversight. More work is needed on the quality of the QDRRs, particularly with regard to the laboratory sections. Since after the Round 11 review, the indicators related to the timely review of QDRRs by PCPs and psychiatrists, have been in less oversight. However, a number of problems with timely review occurred for the QDRRs reviewed. As a result, Indicators c.i and c.ii are at risk of returning to active oversight.	Individuals:

It was positive that when prescribers agreed to recommendations for the individuals reviewed, documentation was presented to show they implemented them. If Center staff sustain their performance, then after the next review, Indicator d might move to the category requiring less oversight.											
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
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;	47% 8/17	0/2	1/2	0/2	2/2	2/2	1/2	0/1	0/2	2/2
	ii. Benzodiazepine use;	88% 15/17	2/2	2/2	2/2	2/2	2/2	1/2	0/1	2/2	2/2
	iii. Medication polypharmacy;	82% 14/17	2/2	2/2	2/2	2/2	2/2	0/2	0/1	2/2	2/2
	iv. New generation antipsychotic use; and	82% 9/11	2/2	N/A	2/2	N/A	N/A	1/2	0/1	2/2	2/2
	v. Anticholinergic burden.	88% 15/17	2/2	2/2	2/2	2/2	2/2	1/2	0/1	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. During this review, problems were noted with the timely review of QDRRs by PCPs and psychiatrists. As a result, these indicators are at risk of returning to active 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% 8/8	1/1	1/1	1/1	N/A	2/2	1/1	N/A	1/1	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	Not rated (N/R)									

Comments: a. For the nine individuals in the review group, three of the 17 QDRRs were completed timely. Often, five to six months elapsed between reviews. No QDRR was submitted for Individual #83, who was newly admitted. In addition, the only QDRR submitted for Individual #114 was completed on 12/24/20, 11 months prior to the Monitoring Team's review.

At the time of the last review, problems also were noted with timeliness, and the Monitor recommended that staff put procedures in place to correct the problems. Given that the problem worsened, this indicator will return to active oversight.

b. The following provides information about concerns noted:

- For Individual #64, the Pharmacy dispensed ferrous sulfate for treatment of iron deficiency. There was no laboratory monitoring for this diagnosis in the labs reviewed. In addition, the individual was prescribed a second-generation anti-psychotic (SGA) and had abnormal values for his A1c: 11/3/20 - 5.6, 5/3/21- 5.7, and 7/26/21 - 6.0. The A1cs progressively increased, but the Clinical Pharmacist made no comments. This increase may have been associated with the use of an SGA. The lab chart did not include the most recent data.
- With regard to Individual #31's QDRR, dated 9/28/21, the individual's Vitamin D was 69 on 6/1/21, and the Clinical Pharmacist made no related comments. A Vitamin D level of 69 is not consistent with the State Office osteoporosis guidelines, which require justification for levels over 50. In addition, the Pharmacy dispensed ferrous sulfate for the indication of anemia, and folic acid for macrocytic anemia. There was no laboratory evidence submitted to substantiate the prescribing and dispensing of ferrous sulfate for anemia.
- Individual #51 had a low glomerular filtration rate (GFR) and was diagnosed with chronic kidney disease (CKD). There was no documentary evidence that he had undergone renal evaluation. The Clinical Pharmacist made no comments regarding the low GFR and medication use.
- As noted above, Individual #114 only had one QDRR submitted. In addition, in the QDRR, dated 12/24/20, the Clinical Pharmacist mentioned that there was "product duplication of an ARB," and suggested that this be discussed with cardiology. However, the Clinical Pharmacist made no related recommendation. This drug regimen continued until the Medical Director reviewed it on 11/17/21, and decided this regimen was not appropriate to continue.
- For Individual #77:
    - In the QDRR, dated 3/16/21, the Clinical Pharmacist noted that the individual's QTc was prolonged. The Clinical Pharmacist signed the QDRR on 3/16/21. On 3/30/21, the PCP signed it, stating that a repeat EKG would be done along with a cardiology referral. The Clinical Pharmacist did not provide the exact measurement for the QTc, and the date of the EKG was not specified. There was no indication that the Clinical Pharmacist made the PCP aware of this concern more immediately. The PCP noted this was likely due to the quetiapine. There was no evidence that a cardiology consult was completed. The PCP did not document any other steps to address the QTc prolongation, which can result in arrythmias.
    - In the QDRR, dated 9/23/21, the Clinical Pharmacist made no comments related to use of Vitamin D3 despite two levels that were above 50.

c. Although this indicator has been in less oversight since after the Round 11 review, problems noted during this review, place these indicators in jeopardy of returning to active oversight. PCPs completed timely reviews for 12 out of 16 QDRRs (75%), and psychiatrists completed timely reviews for 10 out of 14 (71%) applicable QDRRs.

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, due to problems with the production of documents related to Pharmacy's review of new orders, the parties have agreed that the Monitoring Team will not rate this indicator.

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: N/A	Individuals:
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.	

Outcome 4 – Individuals maintain optimal oral hygiene.
This outcome is no longer rated.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Individuals reviewed did not consistently receive necessary dental care on a timely basis. In addition, due to problems noted during the past two reviews with the provision of dental x-rays (Round 16 -67% and Round 17 – 29%), Indicator c will return to active oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	14% 1/7	0/1	0/1	0/1	N/A	0/1	1/1	0/1	N/A	0/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	29% 2/7	0/1	0/1	0/1	N/A	0/1	1/1	1/1	N/A	0/1
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.									

		However, due to problems noted during the past two reviews (i.e., Round 16 -67% and Round 17 – 29%), this indicator will return to active oversight.									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	17% 1/6	0/1	0/1	0/1	N/A	0/1	1/1	N/A	N/A	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	67% 2/3	0/1	N/A	1/1	N/A	N/A	1/1	N/A	N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	N/A	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments: a. though f. Individual #85 and Individual #77 were edentulous. Since the last review, a number of delays occurred with the completion of necessary dental treatment. The following describes concerns noted:

- None of the applicable individuals who had teeth received prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs. The Dental Department did not provide clinical justifications for this lack of dental care.
- For five of seven individuals, Center staff did not provide tooth brushing instruction to the individual and/or the individual's staff, or otherwise offer any rationale to explain why the Center's Registered Dental Hygienist (RDH) did not provide this service.
- Five of six individuals with medium or high caries risk ratings did not receive at least two topical fluoride applications per year.
- For two of three individuals who had needs for restorative work, the Dental Department completed the restoration in a timely manner. The exception was for Individual #64, for whom, on 12/18/19, a dental examination identified a need for restorative work (i.e., multiple restorations and extraction of a non-restorable tooth #31), but it had not been completed.

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
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 in the physical health review group experienced a dental emergency.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for suction tooth brushing plans and their implementation are now assessed as part of the Section F – ISP audit tool.

Outcome 9 – Individuals who need them have dentures.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	88% 7/8	1/1	1/1	0/1	1/1	1/1	1/1	N/A	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. and b. For seven of eight individuals reviewed with missing teeth, the Dental Department provided clinical justification for not recommending dentures. The exception was for Individual #51, who had 13 missing teeth, and whose annual dental examination did not provide an assessment with regard to the appropriateness of dentures. The Center also did not provide and annual dental summary for him. Of note, for Individual #83, the Center had not yet completed a complete dental examination and did not know if he had missing teeth.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.	
Summary: It was good to see that for the acute illnesses/events for which individuals were transferred to the ED or hospitalized, nurses conducted pre- and post-hospitalization assessments. Due to the Center's sustained progress in this area (i.e., Round 14 – 100%, Round 15 – N/A, and Round 16 - 100%, and Round 17 – 80%), Indicator d will move to the category requiring less oversight. It also was positive that for each of the six acute illnesses/occurrences reviewed, nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines. Overall improvements continued with the quality of acute care plans. In two of the five cases, nursing staff thoroughly implemented the plans. Center staff should	Individuals:

continue their efforts to make needed improvements to the quality of the plans and their implementation.											
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	100% 6/6	1/1	1/1	1/1	1/1	N/R	1/1	N/R	1/1	N/R
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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	80% 4/5	1/1	1/1	N/A	1/1		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.	100% 2/2	N/A	N/A	1/1	N/A		1/1		N/A	
e.	The individual has an acute care plan that meets his/her needs.	0% 0/5	0/1	N/A	0/1	0/1		0/1		0/1	
f.	The individual's acute care plan is implemented.	40% 2/5	0/1	N/A	1/1	1/1		0/1		0/1	

Comments: The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #64 – rash on forehead on 5/18/21; Individual #31 – mild head injury on 6/16/21; Individual #51 – ED visit for respiratory distress, unconsciousness, closed head trauma, and use of CPR on 7/3/21; Individual #85 – urinary tract infection (UTI) on 8/27/21; Individual #114 – ED visit for esophageal foreign body on 8/7/21; and Individual #77 – moderate head injury on 7/7/21.

a. It was positive that for each of these acute illnesses/occurrences, nurses performed initial nursing assessments (physical assessments) in accordance with applicable nursing guidelines.

d. It also was positive that for the two individuals who required transfer out to the ED, nursing staff conducted pre- and post-hospitalization assessments.

c., and e. and f. The following provide some examples of findings related to these indicators:

- The following acute care plans met most of the criteria for a quality plan, but were missing a measurable goal defining the clinical indicators nursing would measure: Individual #64 – rash on forehead on 5/18/21, and Individual #51 – ED visit for respiratory distress, unconsciousness, closed head trauma, and use of CPR on 7/3/21.
- Similarly, for Individual #85's UTI on 8/27/21, the acute care plan met most quality criteria. What was missing was a specific goal that was clinically relevant, attainable, and realistic to measure the efficacy of interventions.

- Nursing staff did not thoroughly implement the interventions in the acute care plan for the rash on Individual #64's forehead on 5/18/21. For example, nurses did not complete and/or document dressing changes twice a day. On 5/25/21, nursing staff closed the acute care plan, but no IPN was found to document that the problem was resolved.
- For Individual #114, the acute care plan included an intervention for PRN analgesics for reported pain. This did not appear consistent with the corresponding PCP order, which included Acetaminophen 325 milligram (mg) PRN dose. Review of the MAR showed that she already was prescribed a scheduled dose of 650 mg four times a day (QID). Also, the August Medication Administration Record (MAR) did not include an order for PRN pain medication. In addition, the plan did not include a specific goal that was clinically relevant, attainable, and realistic to measure the efficacy of interventions, or a measurable goal defining the clinical indicators nursing would measure.

  It was positive that nurses generally implemented the interventions included in the plan. However, nursing staff discontinued it on 8/15/21, but on 8/16/21, a nursing IPN stated the plan was to continue. No further IPN was found to show when the problem was resolved.
- On 7/7/21, Individual #77 sustained a moderate head injury as a result of self-injurious behavior (SIB). The acute care plan included an intervention for nursing staff to perform the face, legs, activity, cry, and consolability (FLACC) pain scale and report any pain unrelieved by PRN medication to the PCP. However, according to the July MAR, no PRN pain medication was ordered. In addition, nurses did not complete and/or document assessments of pain. The plan did not include a specific goal that was clinically relevant, attainable, and realistic to measure the efficacy of interventions, or a measurable goal defining the clinical indicators nursing would measure.
- It was positive that nursing staff thoroughly implemented the following acute care plans through to resolution: Individual #51 – ED visit for respiratory distress, unconsciousness, closed head trauma, and use of CPR on 7/3/21; and Individual #85 – UTI on 8/27/21.

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.

The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: IHCPs generally included some, but not all necessary nursing supports. Even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 64	31	51	85	139	114	83	77	59

a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need.	0% 0/12	0/2	0/2	0/2	0/2	N/R	0/2	N/R	0/2	N/R
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/7	N/A	0/1	0/2	0/2		0/2		N/A	
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% 0/12	0/2	0/2	0/2	0/2		0/2		0/2	

Comments: As noted above, the Monitoring Team reviewed a total of 12 specific risk areas for six 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 generally included some, but not all necessary 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. At times, nurses implemented a few of the interventions, but had not implemented other key interventions.

A significant problem was the lack of measurability of the supports. As discussed during the remote review with the Chief Nurse Executive (CNE)/RNCM supervisor, and the State Office Nursing Discipline Lead, Center staff were not familiar with the email that the previous State Office Nursing Discipline Lead sent related to using specific terminology in IHCP interventions to designate when nurses should conduct assessments (e.g., for weekly assessments, designating which day of the week). The State Office Nursing Discipline Lead followed up with the staff, and explained that these would be incorporated into nursing policy.

b. As illustrated below, a continuing problem at the Center was the lack of urgency with which IDTs addressed individuals' changes of status through the completion of comprehensive reviews and analyses to identify and address underlying causes or etiologies of conditions that placed individuals at risk, and modifications to plans to address their needs. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- According to an IPN, dated 7/14/21, staff reported that Individual #31 was limping. After nursing and medical assessments, on 7/15/21, an x-ray showed a right foot metatarsal fracture. According to an ISPA (i.e., documented in an email), dated 7/14/21, the IDT met to discuss the serious injury. During this meeting, the IDT did not review the acute care plan. The IDT's plan was to meet on 7/19/21, to review the orthopedic consult. The next ISPA did not include any information from the orthopedics consult on 7/19/21, and no further relevant ISPAs followed this date. No evidence was found to show that the IDT followed up on his appointment to determine whether or not any changes were needed to his level of supervision (LOS), activities of daily living (ADLs), or the acute care plan (ACP).
- Based on the records submitted, Individual #51 experienced a number of incidents, falls, and/or seizures that resulted in injuries, including mild and moderate head injuries. For example:
    - On 5/4/21, the PCP ordered the mild head injury protocol.
    - On 5/20/21, the PCP ordered the mild head injury protocol after a peer kicked him in the face, and he fell.

- On 5/23/21, the PCP ordered the mild head injury protocol after a peer hit him in the head.
- On 5/27/21, the PCP ordered the mild head injury protocol after he was hit in head by a basketball.
- On 6/19/21, the PCP ordered the mild head injury protocol due to trauma.
- On 6/27/21, the PCP ordered the mild head injury protocol due to the individual banging his head on the wall.
- From 7/3/21 to 7/5/21, he was hospitalized for a seizure with a fall resulting in a moderate head injury.
- On 7/8/21, he sustained a mild head injury, after he was hit on the head.
- On 7/21/21, the PCP ordered a soft shell helmet due to seizures for use daily while out of bed.
- On 8/24/21, he had a seizure that lasted five minutes followed by another seizure15 minutes later. The PCP ordered Stat IM Ativan and transfer to the ED.
- On 9/15/21, he fell and sustained a moderate head injury.
- On 9/22/21, he sustained a mild head injury, after a peer hit him on the head.
- On 9/27/21, the mild head injury protocol was extended for 24 hours due to a "true fall" due to blunt trauma to the head.

Even though the IDT conducted reviews of specific incidents related to the individual's behavior and/or the peer-to-peer aggression, the IDT did not appear to address the larger issue of repeated events associated with being hit in the head, or falling and hitting his head. For example, on 8/28/21, after a hospitalization, the IDT met. However, the IDT did not discuss the five-minute seizure that occurred on 8/24/21, prior to the hospitalization. They did not discuss the institution of PCP orders for prolonged seizure episodes or an individualized seizure management plan, which should have occurred earlier, when he had the seizure on 7/3/21, which also resulted in a hospitalization. No evidence was found to show that the IDT conducted an analysis of the various data to identify the potentially multiple factors contributing to the individual's falls and injuries in order to assist them to the develop a plan to reduce his risk to the extent possible.

- On the following dates, staff transported Individual #85 to the ED for G-tube replacement: 2/9/21, 4/20/21, 5/8/21, 6/16/21, 7/24/21, 8/26/21, and 9/2/21. The IDT documented in ISPAs when three or more G-tube displacements occurred, and relied upon the RNCM for explanations regarding the tube coming out frequently. Given that the Center only serves two individuals with enteral tubes, during interview with Center nursing staff, the Monitoring Team member recommended that they obtain some advice from outside resources, such as their own vendor, a stoma nurse, or nursing staff from other Centers. Such a resource(s) could help them to trouble shoot the problem. The individual had a granuloma, and records showed that the tube leaked. The IDT needed to develop a plan to address the dislodgements as well as the leaking of the tube.
- Over the previous year, Individual #85 experienced a number of infections, including on:
  - 12/31/20 – UTI;
  - 3/3/21 – blepharitis;
  - 6/9/21 – blepharitis;
  - 6/30/21 – blepharitis with a culture showing Staphylococcus Aureus;
  - 8/6/21 – blepharitis;
  - 8/21/21 – UTI;
  - 8/26/21 – redness to stoma, with a culture showing 3+ Mixed aerobic flora. No predominate organism in 48 hours;
  - 8/27/21 – UTI with a culture showing E.coli; and
  - 10/14/21 – blepharitis.

Based on a review of ISPAs, the IDT did not address the infections, the results of cultures, the use of antibiotic therapy, or preventive measures for the repeated UTI and other infections. The IDT did not review related acute care plans, or review the infections IHCP, including staff's implementation of it to determine whether or not it required modification.

- According to flow sheets submitted, at times, Individual #114's diastolic blood pressure fell below 60. Based on a review of ISPAs, her IDT did not review her cardiac status, including graphs showing dates on which her blood pressure medication was held, blood pressure trends such as when the diastolic blood pressure fell below 60, or whether or not she had any associated symptomatology.
- In the six months prior to the review, the following pica events (i.e., according to Document #TX-RG-2111-II.P.1-20) placed Individual #114 at high risk for airway obstruction/respiratory distress:
  - 4/12/21 – marker top/cap;
  - 4/22/21 – plastic bottle cap;
  - 4/23/21 – plastic bottle cap;
  - 4/24/21 – plastic clothes hanger pieces;
  - 6/14/21 – plastic pieces from twistable Crayola;
  - 7/5/21 – plastic bottle cap;
  - 8/6/21 – poker (bingo) chip;
  - 8/19/21 – marker;
  - 8/24/21 – Uno card;
  - 9/12/21 – plastic cap;
  - 10/7/21 – walker knob;
  - 10/8/21 – two quarters, two nickels, and two dimes; and
  - 10/13/21 – plastic screw cap from walker.

After an ED visit, on 8/9/21, the IDT met to discuss it, and review the related Unusual Incident Report (UIR) #2021-281. They noted an Incident Management Review Team (IMRT) recommendation to continue an increased LOS designed to keep her from ingesting items. The ISPA did not include documentation to show that the IDT reviewed data or graphs to assist in understanding the frequency/times of the occurrences, and/or to compare/correlate the incidents with her LOS or other factors that might influence the behavior. The IDT did not discuss the specifics of structured environmental sweeps. For example, the House Manager stated: "room sweeps are now done at all times." It was not clear what this meant in terms of actual frequency, and/or whether or not staff used a tool to assist in the consistency of the sweeps and/or to document their findings.

At an ISPA meeting on 9/30/21, the IDT again did not review graphs or data from any performed environmental sweeps. The current IHCP did not include an intervention for nursing staff to conduct reviews, and the IDT did not discuss modifying the IHCP to include a nursing role in prevention of pica.

Outcome 7 – Individuals receive medications prescribed in a safe manner.	
Summary: Due to the Center's high level of performance with Indicator a related to the administration of prescribed medications (Round 15 – 83%, Round 16 – 100%,	Individuals:

and Round 17 - 94%), it will move to the category requiring less oversight. During about half of the medication administration observations, when issues arose with regard to infection control practices, the Center's nurse auditor identified the same issues as the Monitoring Team member, and took steps to address them, as necessary. Since the last review, Center staff sustained their improvement with regard to the inclusion in IHCPs of respiratory assessments for individuals at high risk for respiratory compromise. However, nurses need to implement these interventions. Improvements also are needed in terms of the timely reporting of medication variances, nurses adhering to infection control practices, and providing instructions to individuals and staff when new medications are administered or when orders change.										
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	Individual receives prescribed medications in accordance with applicable standards of care.	94% 17/18	2/2	2/2	2/2	2/2	2/2	2/2	1/2	2/2	2/2
b.	Medications that are not administered or the individual does not accept are explained.	50% 2/4	N/A	1/1	N/A	N/A	N/A	0/1	0/1	1/1	N/A
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
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.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1	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.	50% 1/2	N/A	N/A	N/A	1/2	N/A	N/A	N/A	N/A	N/A
	a. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	N/A									
	b. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	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.	20% 1/5	N/A	N/A	N/A	1/1	0/1	0/1	0/1	0/1	N/A
f.	Individual's PNMP plan is followed during medication administration.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).										
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.										
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	0/1
	i. If the nurse administering the medications did not meet criteria, the Center's nurse auditor identifies the issue(s).	100% 4/4	N/A	N/A	N/A	1/1	N/A	1/1	1/1	N/A	1/1
	ii. If the nurse administering the medications did not meet criteria, the Center's nurse auditor takes necessary action.	100% 4/4	N/A	N/A	N/A	1/1	N/A	1/1	1/1	N/A	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	40% 2/5	N/A	N/A	0/1	1/1	N/A	0/1	0/1	N/A	1/1
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.	40% 2/5	N/A	N/A	0/1	1/1	N/A	0/1	0/1	N/A	1/1
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.	50% 2/4	1/1	N/A	1/1	N/A	N/A	0/1	0/1	N/A	N/A
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/2	N/A	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A

Comments: The Monitoring Team conducted observations of nine individuals during medication administration, and reviewed their Medication Administration Records (MARs). The Monitoring Team completed full record reviews for the six individuals in the nursing review group. This included Individual #64, Individual #31, Individual #51, Individual #85, Individual #114, and Individual #77.

a. and b. It was positive that for eight of the nine individuals, a review of the MARs showed that nursing staff administered their prescribed medications, or provided an explanation for not administering them. Problems included:

- For Individual #114, on 8/7/21, a nurse circled Losartan, but provided no explanation on the back of the MAR.
- Nurses circled several medications on the MARs for Individual #83. For many, they provided explanations (e.g., medication not available from the Pharmacy). On 10/9/21, Debrox was circled twice, including at 7:00 a.m., when the nurse noted the individual refused, and again at 8:00 p.m., for which nursing staff provided no explanation.

d. It was positive that for individuals who were at high risk for and/or recently experienced pneumonia, or who had G-tubes, IDTs included regular respiratory assessments in their IHCPs. However, nurses did not implement them as written:

- For Individual #85, who had a G-tube and was at high risk for respiratory compromise, the IDT included an intervention for nursing staff to perform a focused respiratory assessment six times daily, and as needed, and report abnormalities to the PCP, including: a full set of vital signs and oxygen (02) saturation for dyspnea, cough/congestion, and/or phlegm/nasal drainage. Based on a review of a sample of documentation, nurses did not consistently complete these assessments six times per day. That said, the IDT should revisit the rationale for performing lung sound assessments routinely six times throughout the 24-hour day (e.g., including at around 4 a.m.). The IDT should consider focusing on the times she receives her medications (i.e., she received medications twice a day), or at other more naturally-occurring times. During the Monitoring Team's observation, it was clear the individual did not like to have her lung sounds assessed, as evidenced by her constant verbal, high-pitched sounds.

  In its comments on the draft report, the State questioned the score of 1/2 for Indicator d.ii, and stated: "It is unclear why d.ii. regarding lung sound checks before and after medication administration was rated 1/2. The monitoring team observed a lung sound check attempt on 11/16/21 at approximately 7:00 pm." The "1" score was for the observation. The "0" was due to the lack of documentation to show that nursing staff consistently completed the respiratory assessments six times daily as required by the individual's IHCP. In other words, two scores are calculated for this indicator, including one based on observation and one based on record review.

- Individual #77 was at high risk for respiratory compromise. His IDT included an intervention for nursing staff to complete a focused respiratory assessment twice monthly, and as needed. Although the IDT did not specify when during each month these assessments should occur, the Monitoring Team member tried to find evidence they were completed, but could not find documentation to support their completion.

e. Similar to the last review, for a number of individuals, nursing staff did not assess and/or document individuals' responses to PRN medication.

g. For less than half of the individuals observed, nursing staff followed infection control practices. It was positive that when problems did occur, the Center's nurse auditor identified them, and took corrective action as needed. The following concerns were noted:

- For Individual #85, Individual #83, and Individual #59 the nurses did not follow the proper procedures for drying their hands, which potentially resulted in cross-contamination. The Center' nurse auditor demonstrated the proper steps.
- For Individual #114, the nurse did not follow the proper procedures for drying their hands, and did not sanitize the front of the medication cart drawers prior to touching them (i.e., this was at the beginning of the medication pass, at which time, the nurse is supposed to clean the cart).

h. and i. Similar to the last review, for a number of individuals, when new medications were introduced or orders changed, nursing staff did not complete and/or document the provision of instructions to the individuals and/or staff, and/or monitor for side effects.

l. and m. With regard to medication variances, for two of the four individuals reviewed for whom nursing variances occurred, medication variance forms were submitted, and no follow-up was needed. For the other two individuals:

- Individual #114 was prescribed Vitamin B12. However, a nurse did not transcribe the medication onto the September MAR. As a result, nurses did not administer it for 22 days. On 9/22/21, a nurse notified the PCP of the variance, who instructed nursing staff to re-start administration of it. On 9/23/21, and 9/24/21, nursing staff documented that the medication was not available. This variance was not discovered for 22 days. No explanation was included in the follow-up documentation to show whether or not the Center was performing 24-hour chart checks, which should have caught the transcription error within a 24-hour period.
- For Individual #83, Center staff submitted documentation indicating he had not had any medication variances. However, based on review of the MARs, on 9/10/21, 9/11/21, and 9/12/21, nurses did not administer Vyvanse 70 mg, and stated the reason was "not available from pharmacy." On 10/26/21, the prescriber decreased the dose to 60 mg, and again, there were days (i.e., 10/27/21, and 10/31/21) when it was not available, but nurses were told to still give the 70 mg dose. Medication variance forms should have been completed, but were not. No explanation was documented for the lack of availability of the prescribed medication.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
The Monitoring Team no longer rates most of the indicators related to this outcome. The Center's responsibilities for PNM-related personal goals/objectives are now assessed as part of the Section F – ISP audit tool. Information about the Center's compliance related to the referral of individuals to the PNMT is provided below											
Summary: It was positive that the two individuals in the review group who met criteria were referred to the PNMT.		Individuals									
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
b.	Individuals are referred to the PNMT as appropriate:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	100% 2/2	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A
Comments: b.i. The Monitoring Team reviewed two areas of need for two individuals that met criteria for PNMT involvement. These areas of need included those for: Individual #51 – falls, and Individual #139 - weight. Both of these individuals were referred to the PNMT.											

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: None of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Many of the PNM action steps that were included were not measurable, making it difficult to collect specific data. Substantially more work is needed to document that individuals receive the PNM supports they require. In addition, in numerous instances, IDTs did not take immediate action, when individuals' PNM risk increased or they experienced changes of status. At this time, these indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/7	N/A	N/A	0/1	0/1	0/1	0/2	0/1	0/1	N/A
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments: a. As noted above, none of the IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. Monthly integrated reviews generally provided no specific information or data about the status of the implementation of the action steps. One of the problems that contributed to the inability to determine whether or not staff implemented supports was the lack of measurability of many of the action steps.

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

- According to Document #TX-RG.2111-II.P.1-20, in the six months prior to the review, Individual #51 fell at least 18 times. On 9/29/21, his IDT held an ISPA meeting after a fall, and referred him to OT/PT to consider a reacher for use in his wheelchair to prevent future falls. He fell when he attempted to reach forward to the floor and his chair tipped over. The OT conducted an assessment, but did not recommend a reacher, because it was too difficult for him to use safely. On 10/11/21, the PT completed a review. According to the PT's corresponding IPN, between 9/27/21 and 12/1/21, the individual fell 23 times. However, this date(s) appeared to be incorrect, given that the final date was past the date of the PT's review. However, according to the PT, between 10/10/19 and 9/30/20, the individual fell 10 times, so his recent fall occurrences showed a significant increase. The PT made no recommendations, though. Although the PT listed a number of supports that had been put in place or tried, the PT provided no assessment of their effectiveness, or information about whether or not staff and/or the individual implemented them as intended.
- Individual #85's IDT did not modify her IHCP to address the multiple ED visits for G/J-tube dislodgements (i.e., 2/9/21, 4/20/21, 5/8/21, 6/13/21, 7/24/21, and 8/6/21. In addition, overall, her aspiration/respiratory compromise IHCP did not meet her needs. It included no strategies to address the prevention of aspiration. The goals did not appear to have relevance to the etiology of her risk in this area. More specifically, the goals related to sitting at the edge of the bed, increasing her standing tolerance, and ambulating 25 feet.
- Individual #139 did not have an IHCP for weight, and the IDT did not develop a change of status (CoS) IHCP. His IRRF identified him at low risk as of 7/20/21, although he had shown subtle weight loss since February 2021 (134), March (not recorded), April (131.5), May (133), and June (129). He was prescribed a 4000-calorie diet. His IDT rated him at low risk for weight, because his body mass index (BMI) was within normal range and he remained within his estimated desired weight range (EDWR) of 104 to 141 pounds.

  On 7/13/21, he weighed 129.6 pounds. By 8/11/21, he had lost 11.6 pounds (i.e., a 9%-weight loss in one month). By 9/13/21, he lost an additional 5.5 pounds (reaching a low of 112.5 pounds on 9/13/21). On 9/16/21, he was referred to the PNMT for unplanned weight loss of 15.1 pounds (12%), since 7/13/21.

  Based on a review of ISPAs, the IDT did not discuss weight loss until they reviewed a neglect allegation on 9/23/21. This allegation related to a lack of documentation of meal refusals from at least July through September. They also discussed the concern that nursing documentation did not reflect any concerns. The IDT made no recommendations due to "PNMT review and IDT will be following the recommendations there. Refer to PNMT review ISPA." The PNMT review ISPA was also dated 9/23/21. At that time, the IDT agreed to meet on 10/14/21, "to discuss the action step of getting him familiar with mealtime." The IDT indicated that a change would be made to the IRRF in the area of weight. The Monitoring Team found no evidence of this or a CoS IHCP. On 9/30/21, the IDT held an ISPA meeting to discuss how to obtain accurate weights (i.e., they considered a mechanical lift). On 10/14/21, the IDT held an ISPA meeting to follow up on recommendations.

- According to Document #TX-RG.2111-II.P.1-20, between 4/9/21 and 9/24/21, Individual #114 fell at least eight times. This included three falls in August 2021, but her IDT did not meet to discuss them, and/or review, and revise, as needed, the supports in place. Her IHCP was missing a number of interventions from the PNMP (i.e., the IDT did not list her rolling walker, van transfers, or use of knee braces for support during ambulation). Without a review, it was not clear whether or not the individual and staff implemented the supports, and if so, whether or not they were effective.
- Individual #114's IDT developed a CoS IHCP for choking, but the Monitoring Team could not find a rationale as to why this was needed. An ISPA, dated 7/16/21, stated that the SLP made an emergency downgrade of the individual's diet to ground, and that she would remain on a ground diet with thin liquids. Nursing staff would no longer administer medications whole, but would now crush them. The IDT noted that a new MD was assigned to the individual. The IDT did not document a rationale for this PNMP update, but noted that it would be reviewed "Monday." Later in the ISPA, the IDT referenced an MBSS in which a bottle cap was found in the individual's throat area, and recommended a gastroenterology (GI) consultation and ground diet texture. The report identified that she probably swallowed the bottle cap "a couple of weeks ago." The IDT noted that an endoscopy would be performed, and the cap would be removed if found. The IDT initiated one-to-one staffing to prevent her from swallowing any objects until the IDT met again. Staff also were supposed to conduct room sweeps" periodically" to remove all objects she could swallow.

  On 7/15/21, the individual was sent to the ED for "extraction." No obstruction showed up in her throat or airway, and she returned to the Center. X-rays done in the ED would not detect a plastic cap, so she was sent to the gastroenterologist for an endoscopy. On 7/19/21, during a subsequent ISPA meeting, the IDT discussed that she had an MBSS on 7/14/21. The SLP had recommended it, because the individual had swallowed a water bottle cap a few weeks before, and had been having vomiting episodes after swallowing food. The IDT reviewed the findings. The IDT's recommendations included "Meal diet: ground, thin liquids, straw, carbonated thin and consecutive swallows are safe." Given that she had increased choking risk with whole medications, the change to crushed medications would occur, and then, once she was cleared by ear, nose, and throat (ENT) or GI, she could return to whole medications. Reflux precautions included the individual remaining upright during by-mouth (PO) intake and for 45 minutes after meals. Because the IDT elevated her choking risk from low to medium, the SLP was to update the choking IRRF and IHCP.

  According to an ISPA for an IDT meeting held on 8/9/21, she self-reported swallowing a poker chip on 8/6/21. It did not appear that she had one-to-one staffing, but this was not clear from the ISPA. According to an ISPA meeting on 8/9/21, on 8/7/21, she was sent to the ED to retrieve the blue poker chip. The IDT reported that the Medical Director had placed her on one-to-one supervision at all times for safety and to prevent her from eating non-edible objects until the IDT could meet. On 8/9/21, the IDT discontinued the one-to-one staffing. On 8/19/21, a subsequent ISPA indicated that on 8/13/21, the Medical Director requested another emergency one-to-one staffing restriction for an emergency colonoscopy. The IDT made no new recommendations, so it was not clear when or if the one-to-one restriction had been lifted. On 8/19/21, she was sent to the ED, because she ingested a marker. According to the ISPA, for a meeting held on 8/20/21, she was placed on one-to-one staffing after the ingestion of the marker, "as she continues to have the marker in her body." The IDT also agreed to restrict her access to markers. The IDT did not further increase her choking risk from medium to high, and her IHCP only related to mealtime safety, which was not the sole reason for her risk in this area. On 9/10/21, after the individual saw the GI specialist, the IDT

removed the one-to-one staffing, per the ISPA. On 9/12/21, she reportedly swallowed a water bottle cap. On 9/12/21, the IDT again recommended placing her on one-to-one staffing.

- On 8/27/21, staff identified that Individual #83 had a deep pressure injury on his left heel. He was newly-admitted, and the OT/PT reported that he had no history of skin breakdown. There was no evidence that they assessed his feet. They reported that he was functional with mobility, and that he tolerated hand-over-hand assistance to scrub his body parts and put on shoes and socks. No evidence was found to show that the IDT held an ISPA meeting to discuss the deep pressure injury on his foot, or to review his plan of care to ensure that preventative interventions were included, and/or that staff and the individual were implementing them. The pressure injury resolved on 9/20/21.
- Between March 2021 and 10/13/21, Individual #77 fell had at least 18 times. On 4/28/21, the IDT held an ISPA meeting to discuss his falls. The IDT noted that for falls related to peer-to-peer aggression in which he was the victim, the IDTs of the "aggressors" put supports in place. They did not specify what the supports were or how they planned to protect Individual #77 as the victim. For the one "environmental" fall, they planned to ensure that he did not sit near the edges of walkways in his wheelchair. They indicated that he had no "true falls," so they did not plan to conduct a falls assessment.

  On 6/8/21, the IDT held an ISPA meeting related to falls. The IDT again noted that supports were provided to the "aggressor" for each incident in which peer-to-peer aggression contributed to a fall. On 5/31/21, his brief caught on his wheelchair causing him to fall. Although the relevance was unclear, the IDT agreed to make sure staff have back-up radios on hand. Staff also were to "be aware and anticipate [the individual's] actions when he is having behaviors and react ahead of time to avoid any injuries."

  In June (i.e., specific date not clear), the IDT held a subsequent ISPA meeting. The PNMT nurse stated: "he is 2 or 3 falls away from being referred to PNMT." The IDT noted that he was becoming more aggressive, disruptive, and asking for radios constantly. His target behavior frequency surpassed the data from May with two weeks remaining in June.

  At an ISPA meeting on 7/20/21, the IDT noted that the individual continued to fall. The action to which they agreed was to provide ongoing training related to staff feeling frustrated when they try to address his behaviors. Although he had "true" falls on 9/18/21, 10/12/21, and 10/13/21, no evidence was found to show that the IDT held further ISPA meetings, and/or made a referral to the PNMT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.	
Summary: Based on two observations, staff completed transfers correctly. However, efforts are needed to continue to improve Dining Plan implementation, as well as positioning. Often, the errors that occurred (e.g., staff not intervening when individuals took large bites, and/or ate at an unsafe rate) placed individuals at significant risk of harm. Center staff, including Habilitation Therapies, as well as Residential and Day Program/Vocational staff, and Skill Acquisition/Behavioral Health staff should determine the issues preventing staff from implementing PNMPs	

correctly or effectively (e.g., competence, accountability, need for skill training for individuals, need to change ineffective strategies, etc.), and address them. This indicator will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	38% 14/37	
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.	N/R	

Comments: a. The Monitoring Team conducted 38 observations of the implementation of PNMPs/Dining Plans. Based on these observations, staff implemented individuals' PNMPs related to positioning correctly during four out of seven observations (57%). Staff followed individuals' dining plans during eight out of 28 mealtime observations (29%). Staff completed transfers correctly during two out of two observations (100%).

The following provides more specifics about the problems noted:

- With regard to Dining Plan implementation, approximately 40% of the errors related to staff not using correct techniques (e.g., cues for slowing, presentation of food and drink, prompting, etc.). Individuals were at increased risk due to staff's failure, for example, to intervene when they took large unsafe bites, or ate at too fast a rate. In 25% of the mealtime observations, concerns with texture/consistency were noted. With three exceptions, adaptive equipment was correct. With two exceptions, staff and the individuals observed were positioned correctly at mealtimes.
- With regard to positioning, it was positive that for all seven individuals observed, necessary adaptive equipment was present. In about 30% of the observations, individuals were not positioned correctly. In addition, in about 30% of the observations, staff had not used equipment correctly.
- For the two transfers observed, staff followed correct procedures.

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	64	31	51	85	139	114	83	77	59
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	N/A				N/A					

Comments: a. None.

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: None of the individuals reviewed had clinically relevant and measurable goals/objectives to address their needs for formal OT/PT services. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	25% 2/8	0/1	0/1	0/1	2/2	0/1	0/1	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/8	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1	
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7	N/A	0/1	0/1	0/2	0/1	0/1	0/1	0/1	
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7	N/A	0/1	0/1	0/2	0/1	0/1	0/1	0/1	
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7	N/A	0/1	0/1	0/2	0/1	0/1	0/1	0/1	

Comments: a. through e. Individual #59 (i.e., based on his assessment) did not require formal OT/PT goals/objectives. However, he had OT/PT-related supports (i.e., an active PNMP). The remaining individuals reviewed had needs for formal OT/PT supports and services, but only Individual #85 had related goals/objectives (i.e., sit at the edge of the bed, and increase left elbow extension).

It was positive that these two goals/objectives were clinically relevant. It was also positive her IDT integrated the goals/objectives into her ISP. This was an important factor to ensure that an individual's IDT approved the OT/PT goals/objectives, was aware of the progress with regard to their implementation, and could build upon and integrate those goals/objectives into a cohesive overall plan However, the goals/objectives were not measurable. Neither of the goals/objectives provided clear criteria for achievement (e.g., the number of trials to be offered and/or successfully completed). In addition, QIDP monthly integrated progress reports, including data and analysis of the data, were not available to her IDT in an integrated format and/or in a timely manner, nor did the Center submit related IPNs from Center habilitation staff. This made it difficult for the IDT to track progress on the goals/objectives, or when progress was not occurring, take necessary action.

The Monitoring Team conducted full reviews for all nine individuals. This included Individual #59, who did not require formal OT/PT goals/objectives, but did have related supports.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: The individuals reviewed did not have measurable strategies and action plans to address their OT/PT needs in their ISPs/ISPAs. These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	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.	25% 1/4	N/A	1/1	N/A	0/2	N/A	0/1	N/A	N/A	N/A

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to OT/PT needs were implemented. As noted above with regard to Outcome 1, the individuals reviewed did not have measurable goals/objectives included in their ISPs/ISPAs.

b. For the three applicable individuals, when termination of an OT/PT service or support was recommended outside of an annual ISP meeting, it appeared the respective IDTs met to review the proposed changes. However, for two of the three individuals, the respective IDTs did not document meaningful discussion about the rationales for the terminations and/or any necessary next steps. The following describes concerns noted:

- For Individual #85, Center PT staff provided an insufficient rationale for discontinuing direct PT. The PT discharge summary, dated 8/31/21, stated the individual met two of four goals, but did not modify, or otherwise continue, the unmet goals or provide a rationale for discontinuing them. The IDT then met on 9/10/21, after the discharge summary was written, but the ISPA did not evidence any meaningful discussion about alternatives to the unmet goals.
- On 6/25/21 (i.e., according to the signature page, although the ISPA discussed events after this date), the IDT for Individual #114 met and approved discontinuation of the gait belt, but provided no rationale or discussion of possible related precautions (e.g., additional strategies, precautions, supervision, or supports to prevent falls). There was no evidence that the IDT discussed why the gait belt was being removed from the PNMP.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.	
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores, these indicators will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.	Individuals:

#	Indicator	Overall Score	4	27	85	63	114	71	29	77	
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	67% 6/9	0/1	0/1	2/2	1/1	1/1	1/1	1/1	0/1	
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	44% 4/9	0/1	0/1	1/2	0/1	1/1	1/1	1/1	0/1	

Comments: b. and c. The Monitoring Team conducted observations of nine pieces of adaptive equipment. Overall, some equipment was not in proper working condition, and often, it did not appear to be the proper fit for the individual. The following describes concerns noted:

- Based on observation, the wheelchairs for three individuals were not in proper working condition. This included wheelchairs for Individual #4 (i.e., right side brake needed adjustment), Individual #27 (i.e., leg rests needed to be adjusted as they were not aligned properly and did not provide adequate alignment and support for her lower extremities), and Individual #77 (i.e., the right footrest needed to be adjusted to be properly aligned with the wheelchair).
- Based on observations of Individual #27, Individual #63, and Individual #77 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.
- Individual #85's arm splint appeared to be too large and there was no schedule for skin checks, despite a schedule for wearing it for eight consecutive hours.

Of note, during the Monitoring Team's initial observations, five individuals did not have their eyeglasses with them and/or staff reported they refused to wear them. As the observations continued, more individuals had their eyeglasses with them. Although Center staff included eyeglasses as part of individuals' PNMPs, they are not included in the definition of adaptive equipment in the Settlement Agreement. As such, the Monitoring Team has not included them in the scoring. However, given that eyeglasses can play an important role in individuals' safety, as well as their quality of life, Center staff should further assess what the obstacles are to individuals keeping their eyeglasses with them, and wearing them, and, then, address them.

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 11 outcomes and 31 underlying indicators in the areas of skill acquisition, engagement, dental and communication. At the last review, three indicators were in the category of requiring less oversight. For this review, one indicator in the area of communication will move 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.

Skill acquisition plans (SAPs) were not progressing and/or progress could not be determined. Actions were not taken when there was no progress.

The written SAPs contained many of the required components, but all were also missing important components and/or contained components that did not meet criteria. There were, however, some positive aspects of many of the SAPs.

Most individuals were not regularly engaged in activities when observed by the Monitoring Team.

Based on observations for individuals' use of AAC devices across the campus, a number of issues require further staff training to assist with the correct implementation and use of these systems. For example, improvement is needed with the timing and types of prompts and interactions staff provide to individuals to help to shape more functional use of these devices. This should involve modeling for direct support professional staff, as well as further training and monitoring.

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: SAPs were not progressing and/or progress could not be determined. Actions were not taken when there was no progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
6	The individual is progressing on his/her SAPs.	0% 0/7	0/1	0/2				0/2		0/1	0/1
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A									

8	If the individual was not making progress, actions were taken.	0% 0/5	0/1	0/2						0/1	0/1
9	(No longer scored)										

Comments:
6. None of the SAPs were judged to be progressing (e.g., Individual #144's access his music SAP). Several SAPs graphs were not interpretable (e.g., Individual #17's apply eye drops SAP- see indicator #17 for more details) and, therefore, not scored. Other SAPs had no data (e.g., Individual #97's wash hands SAP).

8. The progress notes for five SAPs that were not progressing (e.g., Individual #29's turn on/off his tablet SAP) indicated no action following a lack of progress.

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

Summary: SAPs contained many of the required components, but all were also missing important components and/or contained components that did not meet criteria (as detailed in the comments below). Some positive examples are noted at the end of the comments, too. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
13	The individual's SAPs are complete.	0% 0/16	0/1 6/10	0/3 20/29	0/2 16/20	0/3 18/30	0/1 8/9	0/2 13/19	0/1 13/19	0/1 7/10	0/2 16/20

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.

None of the SAPs were judged to be complete. Even so, all of the SAPs contained many of these components. For example, 80% of the SAPs had a plan that included:

- a plan based on a task analysis
- operational definitions of target behaviors
- relevant discriminative stimuli
- teaching schedule
- specific consequences for correct responses
- specific consequences for correct responses

Regarding missing components:

- The majority of the SAPs did not contain a clear behavioral objective. For example, the training objective for Individual #64's turn on his CD player read "Individual #64 will turn on his CD player independently in 80% of trials per step." This objective does not, however, include how long he needs to maintain this skill at this prompt level. A complete behavioral objective might read "Individual #64 will turn on his CD player independently in 80% of trials per session for three consecutive months."
- The majority of SAPs combined individual skill steps with staff training instructions. This often made identifying the skill steps difficult for staff. For example, Individual #97's brush his teeth SAP had multiple pages of staff instructions and individual prompts for DSPs to read through, making implementation of the SAP particularly challenging. Keeping individual skill steps (the task analysis) separate from staff training instructions will likely make it easier for DSPs to quickly review and reference the SAP during skill acquisition training.
- Most of the SAPs included multiple steps. The documentation instructions indicated that staff should record the most intrusive prompt required to complete the skill. It was not, however, clear how staff should score the multiple steps. In fact several SAPs (e.g., Individual #17's brush his teeth SAP) had a different number of steps on the training sheet than on the data sheet. The multiple data paths for SAPs with multiple steps made visual interpretation of the graphs very difficult (e.g., Individual #144's access music SAP). It is recommended that Rio Grande SC consider total task training (where every step is trained) and score the percentage of steps completed at the objective prompt level. Or, the Center could consider the training of one step of the task analysis at a time. If the latter type of training is used it is important to (1) identify the current training step, (2) instruct staff how to address the steps following the training step, and (3) instruct staff how to respond if an individual is no longer completing a previously achieved step.
- Some SAPs did not include a generalization plan (e.g., Individual #17's brush his teeth SAP). A generalization plan specifies how the facility will ensure that the skill is generalized to other situations, environments, etc. (e.g., the individual will be asked to engage in the activity on campus, in the community, and when on home visits).

There were, however, some encouraging SAP developments. Rio Grande SC did an excellent job of individualizing the consequences for correct responses. For example, Individual #29's turn on/off his tablet SAP instructed staff to allow Individual #29 to watch a preferred video for 30 minutes following correctly turning on his tablet. This represented a dramatic improvement from the last review. It was also encouraging to see that Individual #148's recently revised identify picture cards SAP had a clear objective, and that staff and individual behaviors had been separated in the SAP training sheet.

Outcome 5- SAPs are implemented with integrity.

Summary: More than half of the SAPs could not be observed due to the individual refusing to participate or being unavailable for observation. Of the four that were observed, three were implemented correctly as written. The Center was not regularly checking implementation integrity. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
14	SAPs are implemented as written.	75% 3/4	Refused	0/1	1/1	No SAPs	Off campus	Refused	Refused	1/1	1/1

15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/16	0/1	0/3	0/2	0/3	0/1	0/2	0/1	0/1	0/2

Comments:

14. The Monitoring Team attempted to observe implementation of one SAP for each individual, but were only able to observe the implementation of four SAPs. The other five SAPs could not be observed because:

- Individual #43, Individual #70, and Individual #31 repeatedly refused to participate in their SAPs.
- Individual #64 was scheduled to have his turn on his CD player SAP observed on the last evening of the remote review, however, at the scheduled time he was off campus at a doctor's appointment
- Individual #17 was discharged from the program when the remote review began, but returned to the program by the end of the review. His SAPs, however, were not established by the end of the review week.

Of the four SAPs that were observed:

- Individual #97's wash his hands, Individual #29's turn on/off his tablet, and Individual #148's identify picture cards were implemented and recorded as written.
- Individual #144's access his music SAP was also implemented as written. The staff indicated that Individual #144 completed the SAP with gestures, however, the DSP was observed to provide physical guidance to complete one of the steps.

This represents an improvement from the last review when none of the four SAPs observed were implemented and recorded as written.

15. Rio Grande SC established that each SAP would have integrity measures once a quarter. At the time of the remote review, 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: Performance remained about the same as at the last review. That is, one third of SAPs were regularly reviewed, and none of them met criteria for graphing summaries. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
16	There is evidence that SAPs are reviewed monthly.	31% 5/16	0/1	3/3	0/2	0/3	0/1	1/2	0/1	0/1	1/2
17	SAP outcomes are graphed.	0% 0/16	0/1	0/3	0/2	0/3	0/1	0/2	0/1	0/1	0/2

Comments:

16. The QIDP monthly reviews of some SAPs included a data-based review (e.g., Individual #144's access his music SAP). Some SAP reviews, however, did not include SAP data, so SAP progress could not be assessed (e.g., Individual #64's turn on his CD player SAP). Other SAPs were not reviewed (e.g., Individual #31's turn water on/off SAP).

17. Some SAPs did not have graphed data (e.g., Individual #144's turn on the water SAP). The visual interpretation of many SAPs was difficult due to the graphing of multiple steps on each graph (e.g., Individual #31's turn on/off the water SAP). Other SAPs had only one step graphed, yet the skill was described as a whole task including several steps (e.g., Individual #17's brush his teeth SAP).

It is suggested that Rio Grande SC simplify the graphs by training and graphing one step at a time, or graphing the percentage of steps implemented at the target prompt level if multiple steps will be trained at each session (i.e., whole task arrangements).

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

Summary: Most individuals were not regularly engaged in activities. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 31	144	148	17	64	70	43	29	97
18	The individual is meaningfully engaged in residential and treatment sites.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were 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.	0% 0/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

18. The Monitoring Team directly observed all nine individuals the during the remote virtual review week. Eight of the individuals were observed multiple times across various settings on campus. Individual #17 was observed once because he was readmitted to the program at the end of the review week. The Monitoring Team found Individual #17 and Individual #43 to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. Rio Grande SC regularly conducted engagement measures in the residences and vocational site. Due to COVID-19 precautions, the treatment sites were restricted, therefore, this indicator will be based on the residential engagement levels. The goal level of engagement in the residences was 80%. Those levels were not achieved in any of the individuals' residences.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.

Summary: Community activities were again occurring. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	31	144	148	17	64	70	43	29	97
22	For the individual, goal frequencies of community recreational activities are established and achieved.	11% 1/9	0/1	0/1	0/1	1/1	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. Individual #17 had a goal of 15 community outings a quarter, and there was documentation of 16 outings in the last quarter. Individual #43, Individual #70, Individual #64, Individual #148, and Individual #31 also had individualized community outing goals (which was good to see), however, available documentation indicated that they did not achieve them. Individual #29, Individual #97, and Individual #144 had documentation of several community outings per month, however, they did not have community outing goals.

23. No data on occurrence of SAPs in community were available

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary:			Individuals:								
#	Indicator	Overall Score									
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

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.
The Monitoring Team no longer rates this outcome. The Center's responsibilities for these goals/objectives are now assessed as part of the Section F – ISP audit tool.

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 and measurability of communication goals/objectives. 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	64	31	51	85	139	114	83	77	59
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	N/A	0/1	0/1	0/1	0/1	N/A	0/1	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/5		0/1	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).	0% 0/5		0/1	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.	0% 0/5		0/1	0/1	0/1	0/1		0/1		

Comments: a. and b. Based on the documentation submitted, Individual #64, Individual #114, Individual #77, and Individual #59 had functional communication skills and did not require formal communication goals/objectives. The remaining five individual did require formal communication goals/objectives, but none had goals objectives that were clinically relevant or fully measurable.

c. through e. Overall, QIDP monthly reviews did not include specific data reflective of implementation of the goals/objectives sufficient to complete an analysis of progress, or if progress was not being made, to take necessary action.

The Monitoring Team completed full reviews for the nine individuals. This included Individual #64. He had functional communication skills, but the Monitoring Team selected him for a full cross-team review. Individual #77 and Individual #59 also had functional communication skills, but were part of the core group, so they had full reviews, as well. Individual #114 had functional communication skills and was part of the outcome group, but her Physical/Nutritional Management Plan (PNMP), included staff instructions related to her communication needs (i.e., visual and hearing), so a full review was also conducted for her.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.	
Summary: The applicable individuals reviewed did not have measurable strategies and action plans related to communication included in their ISPs/ISPAs. To move forward, QIDPs and SLPs should work together to make improvements with regard to the inclusion of strategies in ISPs, and to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.	Individuals:

#	Indicator	Overall Score	64	31	51	85	139	114	83	77	59
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	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.	0% 0/2	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A
	Comments: a. and b. 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. However, as described above with regard to Outcome 1, the applicable individuals did not have measurable ISP action plans to address their communication needs. In addition, the IDTs for Individual #85 and Individual #139 did not implement their goals/objectives, but also did not meet to terminate them.										

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: Given that during the last two review periods and during this review, the individuals often had their AAC devices present or accessible during observations (Round 15 – 78%, Round 16 – 90%, and Round 17 – 88%), Indicator a will move to the category of requiring less oversight. 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	142	144	85	63	1	31	38	97	62
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	88% 7/8	0/1	1/1	N/A	N/A	1/1	N/A	1/1	1/1	1/1
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	50% 4/8	0/1	1/1	0/1	N/A	1/1	N/A	1/1	0/1	1/1
			Individuals:								
#	Indicator		29	57							
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1							
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	N/A							

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.	N/R

Comments: a. and b. Only seven of 11 individuals observed had their AAC devices present and readily accessible. Even when the devices were present, individuals often did not use them in a functional manner, and Center staff did not provide needed prompts for them to do so. The following describes concerns noted:

- Individual #142 did not have their switch access device to turn on their radio present or readily accessible.
- Individual #85 and Individual #31 did not have their switch access devices to turn on their radios present because the staff instructions did not reference the need for them to be present at all times, but Center staff were able to retrieve them upon the request of the Monitoring Team. Individual #85 was not able to functionally use her device with staff assistance. The Monitoring Team was unable to observe Individual #31 use his device, because it was only used during implementation of a skill acquisition plan (SAP) that was outside of the observation period. Of note, communication strategies should be integrated as appropriate into all aspects of the person's day, not just during SAP implementation.

  In the State's comments on the draft report, they referenced integration of the communication dictionary and strategies in documents such as the PNMP and ME book. This is different from integration of the AAC device(s) throughout an individual's day, which was the basis for the Monitoring Team's observation.
- The AAC devices (i.e., two-window devices) were present for Individual #97 and Individual #29, but based on observations, Center staff were not using them in a functional manner.
- Based on observations for the use of AAC devices across the campus, a number of issues required further staff training to assist with the correct implementation and use of these systems. For example, improvement is needed with the timing and types of prompts and interactions staff provide to help to shape more functional use of these devices. This should involve modeling for direct support professional staff, as well as further training and monitoring.

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

This Domain contains five outcomes and 20 underlying indicators. At the last review, three of these indicators were moved to the category of requiring less oversight. For this review, one additional indicator was 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.

Despite ongoing COVID-19 challenges to the transition process, the Center had completed six transitions since the previous review, although one of the individuals returned during this remote review.

It was very positive to see that for one individual, the CLDP included clear competency criteria for pre-move provider staff training supports. This was an important step forward.

While the PMM process continued to need some improvements, it was positive that the PMM often stated the evidence obtained of support implementation in clear categories of observation, documentation and interview. This helped to confirm the reliability of the data relied upon to determine if individuals were receiving supports as needed.

The adequacy and measurability of pre-move provider staff training supports continued to be an area for improvement. While one of the two CLDPs reviewed did specify the competency criteria by which provider competence could be measured, the other did not. In addition, the competency testing for both individuals still did not address many of the individuals' important needs.

Both individuals had behavior support needs, but one had CLDP supports to address those. Importantly, one individual was receiving Clozaril, a medication that can only be prescribed and provided by medical practitioners and pharmacies registered in the REMS database, and then only if certain protocols are also followed. As the Monitoring Team has frequently noted, this requires careful pre-move planning and very specific set of pre and post-move supports, which this CLDP did not clearly state. It was positive that State Office staff participating in our interview were very aware of these protocols and offered their assistance to the Center.

The PMM was able to articulate follow-up action taken for unmet supports, however, there was no documentation in the PMM Checklists about this. The PMM should use the designated Areas of Concern section of the PMM Checklist for this purpose.

Discipline discharge assessments continued to need significant improvement, especially with regard to recommendations to support the transition process, such as for provider training, and for supports needed for community living. Some assessments

did not offer any meaningful recommendations (e.g., the behavioral assessment for one individual), while others sometimes had very important support needs identified in the assessment narrative, but not included in the recommendations.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.

Summary: Rio Grande SC transitioned six individuals since the last review (i.e., about 10% of the census), though one of these individuals returned to the Center (coincidentally, during the week of the monitoring review). There were many improvements in the development of a set of measurable CLDP pre- and post-move supports, though more work was needed in order to meet monitoring criteria. Both indicators will remain in active monitoring

#	Indicator	Overall Score	Individuals: 103	128							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments: Despite ongoing COVID-19 challenges to the transition process, the Center had completed six transitions since the previous review. Two were included in this review (Individual #103 Individual #128.). Both individuals transitioned to group homes that were part of the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the Rio Grande SC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. This process needs to start with the development of clear and detailed pre-move training supports that include specific competency criteria. Those criteria should answer the question "what are the important things provider staff need to know, and know how to do, to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know, and can perform, each one. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 11 pre-move supports for Individual #103 and six pre-move supports for Individual #128. For both individuals, many of the pre-move training supports addressed pre-move training for provider staff. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. Previously, the Monitoring Team found that Center staff needed to prioritize ensuring that all pre-move training supports provide specific competency criteria for each topic. For

this review, it was positive to see that Center staff had begun to make the needed improvements, but additional work was still needed. The following describes the progress observed, as well as areas still needing improvement.

- For Individual #103, it was very positive to see that the six pre-move supports for provider staff training generally provided specific competency criteria they would need to meet. But as described further below, it did not appear that the competency criteria were consistently comprehensive, based upon his needs. Even so, this was still an area of significant improvement.
- For Individual #128, the best example of defining competency criteria was for the habilitation therapy pre-move training support. On the other hand, the nursing and behavioral health pre-move training supports only referenced broad topics and did not provide specific and individualized competency criteria. Two other pre-move training supports (i.e., for Special Considerations and Dysphagia) provided some clear competency criteria, but still had some broad components that did not make clear what staff needed to know about him. For example, one of the special considerations criteria simply stated provider staff should refer to his communication strategies, rather than citing the specific strategies they needed to know. Based on documentation provided for review, Center staff had identified eight such strategies for provider staff knowledge.
- The Monitoring Team reviewed the Center's pre-move provider testing to assess whether it clearly and comprehensively evidenced staff knowledge and competence based on the individuals' assessments. Overall, the testing still did not fully address many of the assessed needs or what provider staff would likely need to know, or know how to do. The following provides examples:
    - For Individual #103, the CLDP did not specify any behavioral pre-move training supports, although Center staff did complete training in this area and administered a quiz. Without defined competency criteria, it was unclear how well the training and quiz addressed his important needs. However, based on his behavioral health assessment (BHA) and Positive behavior Support Plan (PBSP), the quiz focused primarily on what provider staff should do if target behaviors occurred, but only minimally on a lengthy list of preventative strategies. The sole question in that regard was "what are some ways to teach replacement behavior," and the acceptable answer was to model greeting and give fist bump. However, the PBSP listed many more environmental and communication strategies that the quiz did not address. Conversely, for Individual #128, the CLDP included a pre-move training support with clear (if not comprehensive) competency criteria, but Center staff did not provide any evidence they provided pre-move training or obtained evidence of provider staff criteria.
    - For Individual #103, the Physical/Nutritional Management Plan (PNMP) quiz included nine multiple choice questions. As the Monitoring Team has previously suggested, relying solely on multiple choice does not meaningfully test provider staff knowledge retention. That is, Center staff had reverted to this option, after having included some fill-in-the-blank requirements the last time the Monitoring Team reviewed Center transitions. Also, the quizzes did not address some of his important needs in this area. For example, while another quiz asked staff whether he needed his food items flattened on his plate, it did not probe staff knowledge of the purpose (i.e., to prevent overfilling his spoon and eating too fast). The quizzes also did not address the additional strategy of teaching him to only scoop once at a time, rather than twice. Additionally, Center staff should consider other requirements for demonstration of competency (e.g., asking staff not only to

name the assistive equipment he requires for meals, but also requiring staff to demonstrate that they understand how to use the equipment).

- For Individual #128, the PNMP competency test included 11 multiple choice questions that covered many of his needs. However, some of the questions did not cover his needs as comprehensively as required. For example, based on the competency criteria defined in the corresponding pre-move training support, his mealtime positioning requirements included the following: seated upright on Rifton dining chair and table at chest level, with provider staff at eye level; for provider staff to assist Individual #128 in and out of the dining chair and to lock and unlock the wheels on the dining chair. The PNMP quiz asked what type of assistive equipment the individual used, which included the Rifton chair, and another quiz included a question about locking and unlocking the wheels, but neither covered the remaining positioning requirements.

- Post-Move: The respective IDTs developed 25 post-move supports for Individual #103, and listed 40 post-move supports for Individual #128. At the time of the previous review, the Monitoring Team noted that supports often provided explanatory notes that clarified the purpose, intent, and staff instructions, which was a positive practice, but still needed to ensure all supports provided the PMM with clear and measurable criteria or indicators that could be used to ensure supports were being provided as needed. There was some progress noted for this review, but there continued to be examples of post-move supports that used vague language and did not provide clear expectations about needed staff actions or about outcomes:
    - Individual #103's CLDP included post-move supports that called for provider staff to judge whether significant changes occurred in his swallowing and eating capabilities, but did not provide any baseline criteria or examples of what might constitute a significant change.
    - Individual #103's post-move supports did not specify the head of bed elevation for his hospital bed or how often the MOSES and DISCUS should be administered to evaluate potential side effects (i.e., it stated "on a frequent basis"). His post-move support for psychiatric visits specified the date for the initial visit, but otherwise only indicated it should be on a regular basis. None of these provided the measurable criteria that could clearly inform provider staff of the expectations for implementation, or be used to verify it.
    - Individual #128's CLDP also included some post-move supports that did not provide criteria or parameters for implementation, including a post-move support for MOSES/DISCUS administration similar to Individual #103's. Another post-move support indicated the provider should create a schedule for him to speak to his mother, but did not provide or recommend a minimum frequency. Another post move support indicated the Center's Psychiatric Nurse Practitioner should make contact with the community psychiatrist (i.e., a clinician-to-clinician collaboration) to discuss his medications and efficacy, but it did not provide a timeframe expectation.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. Neither of the CLDPs fully and comprehensively addressed support needs and did not meet criterion. There was some notable progress in some key areas for Individual #128's CLDP (e.g., monitoring of nursing needs, DSP reporting of signs/symptoms, behavioral interventions for target behaviors, etc.) that can be used as effective examples of how an IDT can develop and individualize post-move supports. However, Individual #103's CLDP did not include post-move supports for his behavioral/psychiatric needs, DSP reporting of signs/symptoms, instructions for mealtime, or many of his habilitation needs. The following provides additional comments:

- Past history, and recent and current behavioral and psychiatric problems: It was positive that the CLDP for Individual #128 included some specific post-move supports that described and/or required the PMM to verify provider staff knowledge of strategies in his PBSP. On the other hand, Individual #103's CLDP did not include any pre-move training support for his behavioral health needs Neither of the CLDPs included supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. The following provides examples:
    - For Individual #103, the psychiatric discharge assessment indicated that, in the past, he had been noted to be responding to internal stimuli, likely auditory hallucinations (i.e., he would become very fearful and act as if he was afraid someone would hurt him). The CLDP did not include any supports for staff knowledge of this history, or of other identified historical behaviors (e.g., property destruction, elopement, and self-Injurious behavior). His PBSP addressed target behaviors of aggression and disruption and included intervention as well as important prevention and communication strategies. As described above with regard to Indicator 1, the pre-move training addressed some of these strategies, but not all. Center behavioral health staff attended the CLDP and noted that provider staff would only need to follow his PBSP if any issues were to arise, but the CLDP did not contain any specific post-move supports related to the implementation of the PBSP. Given the individual's behavioral needs, overall, this was not an adequate approach.
    - For Individual #128, while the pre-move training supports in this area needed work, it was positive the CLDP included five clear and succinct post-move supports stating what provider staff needed to do to address target behaviors of aggression, inappropriate sexual behaviors, and stealing. However, the post-move supports did not address provider staff knowledge of prevention strategies or replacement behaviors. Additionally, his BHA indicated he also had a history of property destruction, elopement, and self-Injurious behavior, but the CLDP did not include supports to ensure provider staff had knowledge of these historical behaviors that might re-emerge in a less restrictive community setting.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed supports in some areas related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments. As described above, though, Individual #103's CLDP did not include post-move supports for many of his needs in these areas. To meet criterion, the IDTs still needed to develop comprehensive supports in this area. The following provides additional examples:
    - Per their Integrated Risk Rating Forms (IRRFs), both individuals had specific nursing assessment requirements. It was very positive to see that Individual #128's CLDP included clear and succinct post-move supports describing these expectations. On the other hand, for Individual #103, the CLDP did not include post-move supports to address the ongoing nurse monitoring needs outlined in his nursing discharge assessment (e.g., respiratory compromise/aspiration, dental, gastro-intestinal/constipation, cardiac disease/circulatory issues/edema, weight, diabetes/metabolic syndrome and infections/skin integrity).
    - It was also positive that, in most instances (e.g., skin integrity, medication side effects, cardiac, etc.) Individual #128's CLDP included post-move supports for direct support staff (DSP) monitoring of pertinent signs and symptoms. However, while Individual #103's pre-move training supports provided some detail about the need for DSP monitoring with regard to GI needs, this did not address all of his monitoring needs, nor did the CLDP include any related post-

move supports. For example, the CLDP did not include a post-move support for tracking his bowel movements and reporting to nursing if he did not have one within two days.

- For both individuals, the respective IDTs did not include post-move supports that addressed their supervision needs.
- For both Individual #103 and Individual #128, the habilitation therapy assessments contained important recommendations the CLDPs did not fully address or address at all. The following provides examples:
    - For Individual #103, the Center speech-language pathologist (SLP) recommended that within three months of transition, he should have an assessment of potential for the improvement of his oral motor structures and possible diet texture upgrade. Based on his discharge assessment, this was a support that had been pending at the Center, but the IDT did not reference it in his CLDP.
    - The communication assessment for Individual #103 also recommended that a licensed SLP evaluate his communication skills via a comprehensive assessment to determine areas of communication that required a treatment plan, and to create and implement the treatment plan with a home program for provider staff to use to reinforce his skills. The CLDP did not include a support.
    - For Individual #128, on 3/18/21, the IDT held an ISPA meeting and agreed to implement a new program that allowed him to have a small amount of preferred snack foods (e.g., Fritos) that were of a texture above his approved ground diet. In the ISPA documentation, Center habilitation staff described a detailed protocol and indicated the PNMP would be updated to reflect it. This was particularly important for the individual, due to his frequent attempts to take snack foods outside his approved texture from others, but in an uncontrolled manner.
- For Individual #128, the CLDP did not include critical supports that comprehensively described the needs associated with the administration of Clozapine. The Monitoring Team has repeatedly outlined these requirements. Even so, while his CLDP included a post-move support for monthly CBCs, it did not include the specific protocol required for the monthly monitoring of the individual's absolute neutrophil count (ANC). To reiterate, this protocol is known as the Clozapine Risk Evaluation and Mitigation Strategy (REMS) and is required due to an elevated risk for serious, life-threatening infection associated with the medication's administration. Due to the significant risk for harm, only accredited physicians can prescribe the medication, and only enrolled pharmacies are allowed to dispense. It is critical that IDTs develop, prior to transition, detailed plans about how the provider will ensure there were no breaks in the administration of the medication. These must include, but are not limited to, careful pre-move preparation to ensure community medical/psychiatric and pharmacy providers are enrolled in the federal REMS program. Based on interview, it was positive to hear that State Office staff have worked to develop specific expectations for related pre-and post-move supports and will be working with Centers to ensure future transitions will have the needed supports, as applicable.

- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Examples of areas for improvement included:
    - For Individual #103, the CLDP stated that he expressed preferred future outcomes that included learning to make his own pizza and working at a grocery store. However, the CLDP did not include any specific supports for these personal goals.
    - For Individual #128, the CLDP referenced his ISP goals, including independently operating a mobile device to video chat with his mother monthly, independently placing in a music festival for individuals with special needs, and

independently making a three-course meal in the microwave. The CLDP did include a support for using a mobile device to chat with his mom, which was positive, but none for the remaining goals. He also had a personal goal for working independently as a custodian, and his CLDP included supports for sweeping at home, but none for actual paid employment opportunities

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion.
    - For Individual #103, the Education and Training assessment indicated he would be a great candidate for simple repetitive employment in a work environment that is outdoors or indoors and that he does well in small groups of peers with quiet environment and little distractions. It also indicated he was part of the Center's Client Worker Program and was paid $7.25 per hour for work in housekeeping, grounds keeping, and general maintenance. He performed well in all these areas, with verbal prompts to stay on task, and, between June 2020 through July 2021, had earned over $700. Further, the assessment noted he could correlate money and work as he was motivated by pay, praise, and encouragement. Despite these strengths and aptitudes, the CLDP did not include an employment supports.
    - Individual #128's ISP included a personal goal to work independently as a custodian. The Education and Training assessment also noted that he had a service objective to water plants, which he did well. The CLDP did not include employment related supports.
    - Neither CLDP included specific supports for day habilitation attendance or other ongoing meaningful day activities.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. One of two CLDPs minimally met criterion. While neither CLDP included the positive reinforcement strategies from their PSBPs, it was positive that Individual #103's IDT developed some specific and individualized supports in this area.
    - For Individual #103, the CLDP included several post-move supports describing actions provider staff should take to provide a lifestyle that was reinforcing and motivating. These included providing cardboard for drawing and posters, access to the internet and staff assistance to google for information about topics of interest, weekly outings to purchase specific preferred items, quarterly outings to car or truck shows, and calling his mother every day before bed. While overall, this CLDP met criterion, going forward, it will also be important to include the positive reinforcement strategies described in his PBSP.
    - Individual #128's CLDP included one fairly generic support for positive reinforcement and/or motivating components to his success (i.e., tips for interaction that included using his primary language, making eye contact and ensuring environment is not too loud for him to hear). The Center did not provide a current PBSP and the BHA did not otherwise define specific reinforcement techniques that might have been part of that plan. With regard to a preferred lifestyle, the CLDP included only two broad and generic supports for weekly outings, and one that called for creating a schedule for communication with his mother, which lacked any expectation for how often that should occur.

- Teaching, maintenance, participation, and acquisition of specific skills: Neither CLDP fully addressed the individuals' needs in this area. Examples of missed opportunities in this area included the SAPs recommended by habilitation therapy, as described above in this section. In addition, the Center did not provide a Functional Skills Assessment (FSA) for review for either individual, so the Monitoring Team could not fully evaluate whether the respective IDTs developed needed supports related to teaching, maintenance, participation, and acquisition of specific skills. Of note, both individuals had ISP goals to learn to

prepare meals or snacks, but neither CLDP included any related supports. Overall, the CLDPs focused minimal attention on teaching, maintenance, participation, and acquisition of specific skills.

- The Center SLP assessment noted that, despite having a support for his food be flattened in order to prevent him from overfilling his spoon, Individual #103 would still scoop twice and therefore still overfill his spoon. The SLP noted he was able to scoop once, but this was inconsistent. On 10/23/20, to address safety concerns, the SLP recommended that this be considered as a skill acquisition plan (SAP). The IDT approved the SAP and the SLP assessment indicated it was in the process of being implemented, with a pending PNMP update to include prompts in this area. Individual #103's CLDP did not include any related supports.
- For Individual #128, the communication assessment recommended SAPs or service objectives for both expressive (i.e., name pictures) and receptive (i.e., point to pictures) language. The IDT did not discuss or consider these recommendations. Otherwise, related supports were limited to sweeping and assisting group to clean his room. These supports were not constructed as skill acquisition.

All recommendations from assessments are included, or if not, there is a rationale provided: As reported at the time of the previous review, the documentation of the IDTs' discussion of assessments and recommendations continued to need improvement. As described throughout this section, the CLDP did not consistently ensure that recommendations from assessments were addressed and/or that the IDT provided a coherent rationale when recommendations were deferred or declined. Of note, it appeared that this was due, at least in part, to two factors. First, the assessments often contained important information and recommendations in the body of the narrative, but did not include them specifically in the recommendations section, which made it difficult for the general reader to discern. Second, the assessment summaries in the CLDP tended to miss the same information and recommendations. To create a concise and usable CLDP document, it will be important that Center staff not interpret this to mean they should copy and paste entire assessments into the CLDP, which would be unwieldy. Rather, transition staff and disciplines should work together to ensure that both assessments and the corresponding summaries specifically highlight all important recommendations.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: Post move monitoring was occurring. Various aspects of the post move monitoring process needed some improvement, such as in depth of exploration of evidence and in documentation. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	103	128								
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	0% 0/2	0/1	0/1								
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has	0% 0/2	0/1	0/1								

	been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.										
6	The PMM's assessment is correct based on the evidence.	0% 0/2	0/1	0/1							
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	0% 0/2	0/1	0/1							
8	Every problem was followed through to resolution.	0% 0/2	0/1	0/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A									
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A									

Comments:

4. As described with regard to Indicator 1 above, IDTs needed to:
    - Continue to work toward improving measurability of supports to provide guidance to the PMM as to what criteria would constitute the presence of various supports.
    - Continue to work on developing comprehensive pre and post-move supports for verifying provider staff knowledge and competence, thereby ensuring that the PMM would have the necessary prompts to assess whether provider staff were able to meet individuals' needs, as well as needed benchmarks for making an accurate assessment. As described with regard to Indicator 2 above, both individuals had significant supervision, behavioral health and/or health care needs for which the IDTs did not develop supports.
    - Give additional consideration to the evidence required to reliably confirm implementation of supports.
        - As the Monitoring Team has previously reported, IDTs should consider the three prongs of evidence: 1) interviews of appropriate staff and, whenever feasible, the individual; 2) review of documentation (e.g., various logs); and 3) observations. Whenever possible, IDTs should require at least two, or preferably, all three prongs.
        - The IDTs for these two individuals often only required interview and sometimes both interviews and observations, but needed to consider pairing review of documentation with the interviews and/or observations. As a result of the current deficits in this area, the PMM often relied solely on interview with the individual and/or provider staff to confirm implementation of supports, when review of documentation would be not only appropriate, but also entirely feasible. For example, for Individual #103, at both the seven-day and 45-day PMM visits, the PMM did not document reviewing the medication administration record to confirm he continued to receive his medications as listed in the support. In other examples, the PMM relied on staff interview to confirm that he called his mother nightly, received his weekly allowance, and went on weekly outings. These are opportunities for requiring provider staff to keep logs or other records, which will support the reliability of staff assertions.

As reported previously, the PMM often interviewed provider managers or supervisors rather than the direct support staff who had primary responsibility for implementation of supports. The PMM tended to accept the supervisor's assertions that staff were knowledgeable, but needed to test whether those assertions were reliable by interviewing the staff directly. For example, for Individual

#128, a post-move support called for provider DSPs to report any changes in mobility, presence of skin lesions, swelling, temperature elevations, and throat pain. The PMM only documented interviewing the provider nurse and a supervisor, but should have interviewed a provider DSP.

5. Based on information the Post Move Monitor collected, the Monitoring Team could often not evaluate or confirm whether individuals had consistently received supports due to the lack of reliable and valid data. The PMM's comments and evidence should address the full scope of each support so that its presence could be assessed, but did not consistently do so, as described with regard to Indicator 4 above and Indicator 6 below. The following provides additional examples:

- Due to the lack of many needed post-move supports for Individual #103, it was particularly difficult to determine whether he had all needed supports in place.
- For Individual #128, at the time of the 90-day PMM visit, the provider nurse had been unavailable for interview since the seven-day PMM visit, and the provider was also not able to provide any documentation to show that needed monthly nursing assessments had been completed. In addition, at the time of the 90-day PMM visit, the Center Psychiatric Nurse Practitioner had not still contacted the community clinician.

6. Based on the supports defined in the CLDP, the Monitoring Team often did not find enough documentation and/or the support was not clear enough in its intent to enable an evaluation of the accuracy of scoring. As described above, however, the Rio Grande SC PMM sometimes marked supports as met, without collecting all the required evidence, or based on a plan for implementation. In addition, the PMM sometimes marked supports as in place when the evidence did not support that finding. For example, for both individuals, the PMM sometimes marked post-move supports for various appointments or activities as in place based on provider staff assertions that they were being scheduled. For Individual #103, at the time of the seven-day and 45-day PMM visit, the PMM marked a post-move support for attending a car and truck show as in place, but the evidence provided indicated he had not. Similarly, for Individual #128, at the time of the seven-day and 45-day PMM visit, the PMM marked a post-move support for consultation by a community Board-Certified Behavior Analyst (BCBA) as in place, but the evidence indicated the BCBA had not yet seen the individual at the time of those visits.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. While in some instances the PMM was able to verbally articulate follow-up action taken for unmet supports, overall, there was no documentation in the PMM Checklists to identify follow-up needs and track their resolution. We encouraged the PMM to use the designated Areas of Concern section of the PMM Checklist for this purpose. The following describes examples:

- For Individual #103, the PMM had not identified any instances of need for follow-up throughout the first 45 days, but as described above, he had many needs for which no post-move supports existed. This made it impossible to evaluate whether any follow-up might be needed.
- For Individual #128, the PMM did not document follow-up to resolve the lack of psychiatry collaboration through the first 45 days. At the time of the 90-day PMM visit, the PMM continued to document that Center psychiatry staff had not completed the collaboration, but did not document any follow-up activity to resolve the concern.

- Also, for Individual #128, the PMM checklists appeared to show that he had not received the needed laboratory work (i.e., a monthly CBC with differential) to ensure continued administration of Clozaril. Based on the post-move support for laboratory monitoring, his next CBC was due by 5/1/21. However, based on the documentation, he did not receive his labs until 5/16/21. Of equal concern, at the time of the 90-day PMM visit, the provider nurse was not available for interview and no evidence was provided to show the individual had received the labs. This was compounded by the fact that the PMM did not document reviewing the MAR. The PMM did not document any areas of concern or any specific follow-up related to this issue. While Center staff stated in interview that there had been no break in administration of his medication, the available evidence (i.e., that there was a two week delay in the completion of the required CBC) did not bear that out. This was potentially a matter of some urgency, which the Monitoring Team communicated to transition staff.

9-10. During the monitoring review week, post-move monitoring did not occur. As a result, these indicators were not rated.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.

Summary: These individuals had no negative events occur, which was good to see. One of the other individuals who transitioned, however, had multiple events and returned to live at the Center. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	103	128							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1							

Comments:

11. Neither of the individuals had experienced a PDCT event.

However, of the six individuals who transitioned, two had experienced a negative event. This included Individual #17, who transitioned on 10/27/21, but was part of the review group selected by the Monitoring Team. He experienced multiple PDCT events and returned to the Center on 11/16/21. The Monitoring Team observed the ISPA meeting during which the IDT decided that he should return. While much of this meeting was appropriately devoted to crisis resolution, the Monitoring Team encouraged the APC to re-convene the IDT to further discuss the PDCT circumstances and consider whether any improvements in his transition planning might have resulted in a better outcome. The results of this discussion can then be used to improve the planning process for future transitions.

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: Criteria were met for indicator 13 for this review and for previous reviews, too (with one exception for one individual). Given this sustained high performance, indicator 13 will be moved to the category of requiring less oversight. Various aspects of the requirements for the other indicators were done, but not completely or as required. Therefore, these other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	103	128							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1							
18	The APC and transition department staff collaborates with the LIDDA staff when necessary to meet the individual's needs during the transition and following the transition.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/2	0/1	0/1							

Comments:
12. Assessments did not consistently meet criterion for this indicator and this remained an area of need. At the time of the previous review, transition staff had done some good analysis of the need to improve discipline assessments as an important foundation for development of thorough, measurable, and individualized CLDP supports. They had also reported they would be seeking assistance from the Center Director in development of an improvement initiative in this area. However, for this review, transition staff reported this process had stalled, but they planned to engage the new Assistant Director of Programs (ADOP) in a discussion about how to address assessment improvement. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition:
    - The Center did not provide an updated FSA for either individual.
    - For Individual #103, who transitioned on 9/10/21, the dental (i.e., dated 7/6/21) and psychiatry (i.e., dated 6/3021) assessments were not within 45-days of transition.
    - The PBSP for Individual #128, which Center staff used for behavioral training, was dated 11/2019, so it could not be considered current.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Missing assessments impacted the evaluation of this sub-indicator. In addition, IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status. For example, none of Individual #128's applicable assessments fully documented the Clozapine administration requirements.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Missing assessments impacted the evaluation of this sub-indicator. In addition, many assessments that had been updated did not yet thoroughly provide specific and measurable recommendations to support transition. For example, the nursing assessment and BHA for Individual #103 did not provide any recommendations, nor did Individual #128's BHA.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. As described with regard to Indicator 2 above, there were missed opportunities to make recommendations for community-specific skill acquisition and meaningful employment and community integration.

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

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: As described with regard to Indicator 1 above, while some meaningful progress was made in the development of provider staff competency criteria, as evidenced primarily by Individual #103's pre-move training supports, training did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the materials, rosters

and competency testing for all training provided related to these transitions. The CLDP pre-move training supports showed improvement, but did not yet consistently identify the expected provider staff knowledge or competencies that would need to be demonstrated. In addition, competency testing did not clearly document provider staff had knowledge of all essential supports. The tests provided did not include questions for many supports, as also described with regard to Indicator 1 above.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Neither CLDP met criterion. While both CLDPs included statements with regard to needs for PCP and/or psychiatry collaboration, Center staff should be cautious about potentially excluding other considerations that IDTs might need to make.

- For Individual #103, the CLDP documented that the IDT discussed the need for collaborations between Center and community PCPs and psychiatry. In both instances, the IDT concluded that supports were not needed. However, despite a number of concerns and pending needs expressed by the habilitation therapists, the IDT did not document any consideration of the potential benefit of collaboration with community clinicians.
- For Individual #128, the IDT followed a similar approach, considering whether a PCP and/or psychiatry collaboration was needed and concluded that only psychiatry collaboration was needed. The IDT agreed that the collaboration between the Center's Psychiatric Nurse Practitioner and community Psychiatrist should include a discussion and review of the most recent medication changes, as well as a request to make no changes to his medication regimen within first year. It was positive the IDT considered these needs, but should have explicitly cited the importance of discussing the REMS protocol. While it was also positive the IDT created a specific support for the collaboration to occur, it did not provide a timeframe. Further, based on Individual #128's needs related to the REMS protocol, the IDT should have considered a pre-move support rather than the post-move version. In addition to the foregoing, the CLDP did not evidence that the IDT members discussed potential needs for collaboration with the community counterpart for Center behavioral staff, based on his significant needs. While the IDT may decide that collaboration is not needed, they should document a full discussion of collaboration needs.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Both CLDPs made a partial statement of this consideration. For both individuals, the CLDPs stated that the respective IDTs discussed whether they would benefit from any Center disciplines/professionals to assess his home. Each IDT concluded that this support was not needed because each individual was very independent and did not need assistance with mobility or ambulation. As reported previously, it was positive the Center continued to document some level of consideration for settings assessments, but going forward, should not limit the consideration to the home, but also the day program, as well as consider other needs besides mobility. Overall, Center staff should be cautious about using template statements that are not specific to each individuals' needs and/or do not include all the considerations that IDTs should make. Of note, despite the determination by Individual #103's IDT that no settings assessment was required, the Center physical therapist (PT) did complete such a setting assessment. However, the CLDP did not include a description of the purpose or results. Based on review of the corresponding integrated progress note (IPN) completed by the PT on 10/7/21, the settings assessment revealed a need for follow-up (i.e., the dining table might need modifications so that the individual's feet could be flat on the ground to support him remaining in an upright position), for which there was no documentation of resolution.

17. The CLDP should include a specific statement of the IDT considerations of activities Center and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. For both CLDPs reviewed, the IDT provided a specific section asking for a response to the following question: "IDT discussed whether (the individual) would benefit from provider staff to spend time with (the individual)at RGSC prior to movement or RGSC staff to spend time with (the individual) after his movement?" Neither of these CLDPs meet criterion, however, as described below:

- Individual #103's IDT determined this type of activity would not be needed because he did very well during his pre-placement visit, was very excited to spend time at his new home, and was ready to move in on his date of transition. However, based on a review of his Transition Log, the IDT originally recommended that Center staff spend time with Individual #103 while visiting the community day program and the home when Individual #103 visited. While the Transition Log indicated that Center DSP staff accompanied the individual on tours, this did not meaningfully address the purpose of this indicator, which is to facilitate information sharing between Center and provider DSP staff.
- Individual #128's CLDP documented a similar discussion and rationale, stating the IDT agreed this support was not necessary for the individual because he was "very independent and adapts well to change and is looking forward to his movement." However, on 10/2/20, at the time of his 14-day ISPA addendum, the IDT agreed that Center staff would spend time with Individual #128 at the day hab and group home for several days before he moved to the community. Then, on 3/4/21, the team met and agreed that Individual #128 would have an overnight visit of two nights and three days with the provider that was eventually selected. Based on a review of the Transition Log for that date, the IDT also agreed that Center staff would not need to stay with Individual #128 during the overnight visit. Instead, the documentation indicated the provider's Program Director would be notified that if during Individual #128's visit there were issues, he should contact Center staff, and they could send a preferred staff to the group home. The Transition Log did not state any rationale for the change from the time of the 14-day ISPA meeting, and the ISPA documentation from 3/14/21 did not reference this. In other words, the documentation did not evidence that the IDT gave careful consideration to this need.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. However, it is essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility, and the PMSRs for these two individuals did not accomplish this. The CLDP pre-move supports for pre-move training did not meet criterion for ensuring that provider staff were competent for either individual, as described under Indicator #1 and Indicator #2.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary:			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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

    - Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - 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 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
SUR	Safe Use of Restraint
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus