

United States v. State of Texas

Monitoring Team Report

Rio Grande State Center

Dates of Onsite Review: August 10-14, 2015

Date of Report: October 18, 2015

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

Table of Contents

Background	2
Methodology	3
Organization of Report	4
Executive Summary	4
Status of Compliance with Settlement Agreement	
Domain 1	6
Domain 2	12
Domain 3	37
Domain 4	66
Domain 5	72
Domain 6	72
Section D	73
Appendices	
A. Interviews and Documents Reviewed	97
B. List of Acronyms	105

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 Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) component of the Rio Grande State Center.

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

In mid-2014, the parties determined that the facilities were more likely to make progress and achieve substantial compliance with the Settlement Agreement if monitoring focused upon a small number of individuals, the way those individuals received supports and services, and the types of outcomes that those individuals experienced. To that end, the Monitors and their team members developed sets of outcomes, indicators, tools, and procedures. These were piloted at two SSLCs in November 2014 and December 2014. Implementation began in January 2015. The first round of reviews was scheduled to occur over a nine-month period, and the parties determined that due to the extensive changes in the way monitoring would occur, compliance findings would not be made during this round of reviews. In addition, at the time of implementation, the outcomes and indicators for monitoring each SSLC's quality assurance program and some aspects of the facility's most integrated setting practices were not finalized. This was due to the State and DOJ's continued discussions regarding the most integrated setting practices, and the State's efforts to completely revise its quality assurance system.

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

are in place, and, therefore, for a group of individuals, these deeper reviews will be conducted regardless of the individuals' current outcomes.

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

Along with the change in the way the Settlement Agreement was to be monitored, the parties also moved to a system of having two Independent Monitors, each of whom had responsibility for monitoring approximately half of the provisions of the Settlement Agreement using expert consultants. One Monitoring Team focuses on physical health and the other on behavioral health. A number of provisions, however, require monitoring by both Monitoring Teams, such as ISPs, management of risk, and quality assurance.

Methodology

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

- a. **Selection of individuals** – During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Monitoring Teams.
- b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
- c. **Review of documents** – Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed. The amount of documentation requested by the Monitoring Teams decreased with the changes in the way monitoring was being conducted.
- d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, PBSP and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
- e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
- f. **Scoring and compliance determinations** – The report details each of the various outcomes used to determine compliance with each Domain, and the indicators that are used to determine compliance with each outcome. 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 case reviews. These scores will be used to make a determination of substantial compliance for each outcome. As noted above, the parties agreed that compliance determinations would not be made for the Domains or for the outcomes for this round of monitoring reviews.

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 six domains heads a section of the report.
- b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
- c. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
- d. **Facility self-assessment:** The parties agreed that the facility self-assessment would not be conducted for this round of reviews.
- 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' outcomes, indicators, tools, and procedures documents (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at Rio Grande State Center for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The facility director supported the work of the Monitoring Teams, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Numerous issues, however, occurred with regard to document production. Although Facility staff were responsive to the Monitoring Teams' requests to correct document issues, the Monitors remain unsure that the Facility provided all relevant documents. As a result, the Monitors' findings are based on the documents provided and might not reflect all protections, supports, and services provided to individuals reviewed at Rio Grande State Center. The Facility should work with DADS and its State Office to correct the document production issues to ensure that for the next review, the Facility provides the relevant documents. The following are some examples of these document issues:

- Individual #126 died prior to the review. The Facility reported that a number of requested documents were not available because the record was "closed." An individual's death should not prevent the Facility from providing the Monitoring Teams with items such as reports from medical consultations, Individual Support Plan Addenda (ISPAs), etc.
- The Monitoring Team requested "IPNs [Integrated Progress Notes] for last six months, including as applicable Hospitalization/ER [Emergency Room]/LTAC [Long-term Acute Care] related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc." Despite this comprehensive request from the Monitoring Team, evidently, Rio Grande State Center maintained separate notes on some of these items (i.e., not in the IPNs), but did not provide them, because "they were not requested." DADS State Office should work with Facility staff to conduct a cross-walk between the data sources included in the audit tools and document requests and the equivalent documents at Rio Grande State Center.

During the week of the onsite review and during the week following the onsite review, the Monitoring Teams expressed a number of specific concerns to Facility, State Office, and DOJ regarding Individual #65. Concerns were regarding his medical conditions, physical and nutritional management, risk ratings, history of substance abuse, behavioral health services programming, and community referral. The Monitoring Teams appreciated the State's quick response to many of these concerns, including a set of actions to be undertaken over the upcoming weeks. Details of the Monitoring Teams' concerns and the State's responses are included in the relevant sections of the report below.

As DOJ and the State agreed, the review of Incident Management/Abuse Neglect for Rio Grande State Center was completed using the previous monitoring format because, in the last two rounds of monitoring, the facility was rated in substantial compliance with all of the subsections of section D. The Monitoring Team again found the facility to be in substantial compliance with all of the subsections of section D (i.e., for three consecutive monitoring reviews). Thus, the facility's performance in this area met the criterion to exit from monitoring of this provision of the Settlement Agreement. The specific findings from the review of section D are at the end of this report.

Status of Compliance with the Settlement Agreement

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

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.		
Compliance rating:		
#	Indicator	Score
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	100% 11/11
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	100% 2/2
<p>Comments:</p> <p>1. Eleven sets of monthly data were reviewed: number of crisis intervention restraints, average duration of a restraint, number of chemical crisis intervention restraints, number of mechanical crisis intervention restraints, number of restraints during which an injury occurred to the individual, number of individuals who were restrained, number of individuals who received protective mechanical restraint for self-injurious behavior, number of medical non-chemical restraints, number of medical chemical restraints (including TIVA), number of dental non-chemical restraints, and number of dental chemical restraints (including TIVA). TIVA was excluded from the definition of restraint by the parties, however, the state's data system was not yet able to separate these occurrences from these two data sets.</p> <p>Data from state office and from the facility for the past nine months (October 2014 through June 2015) showed one occurrence of crisis intervention physical restraint and nine occurrences of medical chemical restraints. There were no occurrences of non-chemical restraint for medical procedures, and no chemical or non-chemical restraint for dental procedures. Only one individual received crisis intervention restraint. There were no injuries during crisis intervention restraint and protective mechanical restraint for self-injurious behaviors was not used for any individuals.</p> <p>Thus, state and facility data showed low/no usage and/or decreases in 11 of these 11 facility-wide measures.</p> <p>2. One of the nine individuals reviewed by the Monitoring Team was subject to one crisis intervention restraint (Individual #44). Another individual (Individual #62) had an occurrence of chemical restraint for medical procedure. That restraint was also included in this review.</p>		

Outcome 2- Individuals who are restrained receive that restraint in a safe manner that follows state policy and generally accepted professional standards of care.		
Compliance rating:		
#	Indicator	Score
3	There was no evidence of prone restraint used.	100% 1/1
4	The restraint was a method approved in facility policy.	100% 1/1
5	The individual posed an immediate and serious risk of harm to him/herself or others.	0% 0/2
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	N/A

7	There was no injury to the individual as a result of implementation of the restraint.	100% 2/2
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 2/2
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	Not rated
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	50% 1/2
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 2/2

Comments:

Two restraints were used in the scoring of the restraint-related outcomes and indicators for this facility: the sole crisis intervention restraint, which was a physical restraint (Individual #44 2/28/15) and one of the medical chemical restraints (Individual #62 8/2/15).

5 and 10. The crisis restraint checklist noted that Individual #44 was walking around in the lobby. There was no indication of serious and immediate threat. Further, multiple entries on the FFA document stated that the restraint was not necessary. The restraint review ISPA reported that the restraint did not appear to be justifiable. HRC review noted, "HRC has deemed the restraint to be unjustifiable. Proper interventions were not executed and the individual was not in imminent danger to self or others."

Similarly, the chemical restraint for Individual #62 occurred when he was resistant to change of colostomy bag. At that time, he did not present a danger to himself or others.

9. This indicator was not scored because both restraints met criterion on indicator #2.

Overall, the Monitoring Team was pleased to see the overall low usage of restraint at this facility and the detailed review of the sole crisis intervention restraint. Chemical restraint for Individual #62 should be reviewed to ensure state policy is followed regarding usage, documentation, and review.

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

Compliance rating:

#	Indicator	Score
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 1/1

Comments:

12. The facility also conducts monthly competency checks and includes that information in the QA program.

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.

Compliance rating:

#	Indicator	Score
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	0% 0/1
14	A licensed health care professional monitored vital signs and mental status as required by state policy.	50% 1/2
15	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
16	The individual was checked for restraint-related injuries following crisis	100%

	intervention restraint.	1/1
Comments:		
13. The staff person who restrained Individual #44 was also the restraint monitor who completed the post restraint assessment. He was assisted by the Director of Behavioral Services in preparing the FFA, however, the restraint monitor needs to be someone other than the staff member who implemented the crisis restraint..		
14. One attempt was made to monitor Individual #44's vital signs. Individual #44 refused, but no subsequent attempts were noted on the restraint checklist.		

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.		
Compliance rating:		
#	Indicator	Score
17	Restraint was documented in compliance with Appendix A.	100% 2/2
Comments:		
17. The restraints were documented very well.		

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.		
Compliance rating:		
#	Indicator	Score
18	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 1/1
19	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 1/1
Comments:		

Abuse, Neglect, and Incident Management

The 12 outcomes, and underlying 31 indicators, that comprise this section of the report were not used to monitor compliance with this part of the Settlement Agreement. Instead, the previous format of monitoring was used to review Section D of the Settlement Agreement because the facility had met substantial compliance criteria for all of the provisions of Section D for the two previous monitoring reviews. The Monitoring Teams' ratings and comments for Section D are inserted at the end of this report.

Psychiatry

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen for review are monitored with these indicators.)		
Compliance rating:		
#	Indicator	Score
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:		
47-49. There were no instances of the use of chemical restraint for crisis intervention. This was good to		

see and also resulted in there being no cases to include in the scoring of these two indicators.

Pretreatment Sedation

Outcome 5 – Individuals receive dental pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A
Comments: a. and b. At Rio Grande State Center, they did not administer pre-treatment sedation or TIVA on campus, but referred individuals to external facilities.		

Outcome 9 – Individuals receive medical pre-treatment sedation safely.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed, including:	
	i. An interdisciplinary committee/group (e.g., individual’s interdisciplinary team) determines medication and dosage;	0% 0/4
	ii. Informed consent is confirmed/present;	0% 0/4
	iii. Pre-procedure vital signs are documented.	100% 4/4
	iv. A post-procedure vital sign flow sheet or IPN(s) is completed, and if instability is noted, it is addressed.	100% 4/4
Comments: i. through iv. Based on review of documentation for the group of individuals the Monitoring Team responsible for physical health reviewed, four incidences of oral pre-treatment sedation for medical procedures were identified. Two of these incidences were not included on the spreadsheet the Facility supplied that was supposed to list all uses of oral pre-treatment sedation. The Monitoring Team reviewed documentation related to the use for Individual #62 on 1/7/15 (not on spreadsheet), 1/8/15, and 2/12/15, and for Individual #145 on 2/19/15 (not on spreadsheet).		

Outcome 1 - Individuals’ need for PTS is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS		
Compliance rating:		
#	Indicator	Score
1	If the individual received PTS in the past year for routine medical or dental procedures, the ISP assessments addressed the use of PTS and made recommendations for the upcoming year	N/A
2	Treatments or strategies were developed to minimize or eliminate the need for pretreatment sedation.	N/A
3	Action plans were implemented.	N/A
4	If implemented, progress was monitored.	N/A
5	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A
Comments: 1-5. None of the individuals reviewed were reported to have received PTS (at the facility) for routine medical or dental care for the time period reviewed by the Monitoring Team.		

Mortality Reviews

Outcome 10 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.		
Compliance rating:		
#	Indicator	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.	100% 1/1
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	100% 1/1
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	100% 1/1
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	100% 1/1
e.	Recommendations are followed through to closure.	0% 0/1
<p>Comments: a. Since January 1, 2015, one individual from Rio Grande State Center died. The Monitoring Team reviewed the records for Individual #126. Timely death reviews were completed for this individual.</p> <p>b. through d. The Facility self-identified a number of issues related to the provision of medical care. The Clinical Death Review noted that the MedExec should address documentation expected by primary care practitioner (PCP) and consultant MD (i.e., who provides back-up to the PCP) when an individual is referred for services outside the Facility. The MedExec also was to address the need for PCPs to consult with the specialist should there be a serious recurrent medical condition present or document why such consultation was not sought. It also was recommended that a contract be obtained with an Infectious Diseases specialist. These recommendations did not appear in the Administrative Death Review. That review noted, however, that PCPs should be trained on the requirement for documentation of consultations (i.e., summary in IPN, agree, disagree and IDT referral).</p> <p>e. Based on the documentation submitted, it was not clear that the recommendations were completed. With regard to the Nursing Quality Assurance review of the death, a number of good recommendations were generated. However, a number of the recommendations appeared not to have been implemented. For example, supporting documentation was not provided to show that recommended templates were developed and/or auditing data was collected. More specifically, the auditing data the Facility provided could not be interpreted, because the Facility only provided one compliance score. It did not provide information regarding what indicators were measured, the sample size and population, instructions for auditing, and/or data per indicator per month.</p> <p>The Facility provided training rosters to demonstrate that recommendations related to “Smart Goals” were implemented. However, the Facility did not provide curricula, thus the quality and content of the training could not be determined.</p> <p>The Facility noted that a number of recommendations were not implemented. However, if the Facility’s action plan related to the mortality review recommendations had included the dates when the recommendations were expected to be completed, as well as the actual dates of completion, it would have been easier to interpret it.</p>		

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.		
Compliance rating:		
#	Indicator	Score
a.	ADRs are reported immediately.	100% 1/1
b.	The Pharmacy and Therapeutics (P&T) Committee thoroughly discusses the ADR.	100% 1/1
c.	Clinical follow-up action is taken, as necessary, with the individual.	100% 1/1
d.	Reportable ADRs are sent to MedWatch.	N/A
Comments: a. through c. The Monitoring Team reviewed the following individuals' medical records: Individual #62, Individual #145, Individual #92, Individual #2, Individual #112, Individual #126, Individual #19, Individual #138, and Individual #65. Facility staff identified and reported one ADR for Individual #145. The P&T Committee reviewed the ADR related to Clozaril, and referred it to the Clinical Director for further review. The Clinical Director documented his evaluation in the Integrated Progress Notes (IPNs).		

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.		
Compliance rating:		
#	Indicator	Score
a.	DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 1/1
Comments: a. and b. Rio Grande State Center completed two DUEs in the six months prior to the Monitoring Team's review, including a DUE related to Geodon, for the quarter ending in February 2015, and a DUE related to Abilify, for the quarter ending in May 2015. The minutes from the June P&T Committee were not finalized to identify and confirm completion of the recommendations resulting from the Abilify 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.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.		
Compliance rating:		
#	Indicator	Score
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6
2	The personal goals are measurable.	0% 0/6
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6
<p>Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #92, Individual #65, Individual #112, Individual #62, Individual #98, and Individual #97. The Monitoring Team reviewed, in detail, their ISPs and related documents, interviewed various staff and clinicians, and directly observed each of the individuals in different settings on the Rio Grande campus.</p> <p>1. Most personal goals for individuals remained very broadly stated, general in nature. Personal goals typical for almost every individual were, for example, goals to live in the most integrated setting, to maintain contact with family, and to participate in preferred leisure activities. One individual, Individual #65, had no personal goal for the leisure domain. Although he was referred for community transition, his 2014 ISP noted no goals or recommendations related to community leisure activities. This was particularly concerning because his prior history in the community indicated he spent his free time engaged in high risk activity and would need, among other interventions, some structured activities that would provide alternatives. Health outcomes were similarly very broad in nature.</p> <p>2. Personal goals were almost universally not measurable.</p> <p>3. Reliable and valid data were seldom available for ISP action plans due to issues, such as inconsistent implementation, lack of clear implementation and documentation methodology, and lack of inter-observer agreement.</p>		

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.		
Compliance rating:		
#	Indicator	Score
8	ISP action plans support the individual's personal goals.	0% 0/6
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6
10	ISP action plans supported the individual's overall enhanced independence.	0% 0/6
11	ISP action plans integrated strategies to minimize risks.	0% 0/6

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

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

8. Personal goals were not well defined in the ISPs.

9. Overall, preferences and opportunities for choice were not well incorporated into goals and action plans in any ISP. One individual, Individual #97, had several well-integrated ISP action plans for using various communication devices (one was a SAP and two were SOs) for the intent of promoting his ability to make choices in his daily life. This was good to see, however, both SOs were subsequently discontinued with no rationale given.

10. There was little emphasis on skill acquisition or learning overall. Again, the communication SAPs and SOs for Individual #97 would have been most likely to result in increased independence, but the discontinuation of the SOs effectively reduced the opportunities to generalize these skills outside of the dining room. In another example, Individual #62 was fed by staff because he ate too fast and overstuffed his mouth, but there was no plan to teach appropriate dining skills.

11-12. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well integrated. Action plans need to be developed to address individual's elevated risks, especially those identified by the IDT and documented in the IRRF portion of the ISP, yet the IDTs were not regularly addressing significant risk factors or correlating across risk areas when performing risk assessments. For example:

- Individual #65 had complex health needs that were not addressed comprehensively by the IDT.
- Two individuals (Individual #112, Individual #65) with significant behavioral health risks were rated to be at low risk in that category.
- Individual #98 was rated to be at low risk for falls despite frequent seizures, frequent periods of unsteadiness, and requiring a helmet to prevent related injury.
- The IDT failed to thoroughly assess fall risks and integrate strategies into plan in a timely manner for Individual #97, despite frequent falls documented for many months dating back to February 2015, an ISPA was not held until 7/31/15.

During the week after the onsite review, the Monitoring Teams shared concerns about Individual #65 with the State, including that his related behavioral health needs and risks had not been adequately assessed or addressed by his IDT. His current IRRF rated his risk for behavioral health problems as low, despite multiple restrictions, 1:1 staffing, and noncompliance regarding food and drink consumption as the justification for those restrictive practices. The current PBSP did not address this noncompliance. Compulsive liquid consumption had been an ongoing issue for some time, but behavioral data had not been collected that could serve as part of an appropriate assessment. The lack of these data also precluded a

thorough evaluation of potential psychiatric symptoms and whether there is a psychogenic component related to the compulsive consumption of liquids.

In its response, the State wrote, "The previous PBSP was dated October 2014. At the time, behavioral issues with aggression were minimal. As a result, it was rated low in the IRRF. However, within the last three weeks, fluid restrictions were implemented, which caused an increase in his irritability and anger. Last week a referral was made to the BCBA to address Individual #65's behaviors. The BCBA has been interviewing staff and reviewing behavioral data. In the meantime, the BCBA will develop behavioral interventions which will be included in the special considerations and will train staff on replacement behaviors. Interventions to be considered include the Alternative to No method, scheduled drinking time [... ..]. The IDT agreed to increase the IRRF rating for behavioral from low to high."

13. Overall, there was a lack of focus on specific plans for community participation that would have promoted any meaningful integration. One possible exception for Individual #112 was attending church off campus, but Monthly Reviews provided no evidence this had occurred. Each of the six ISPs reviewed contained no assessment recommendations for community participation and integration.

14. Consideration for day programming in the most integrated setting had not been assertively addressed for any of the six individuals. The only employment options available were bagging rocks and shredding. The only positive noted was that the IDT recommended an action plan for Individual #65 for a DARS referral as preparation for community placement. Even so, there had been, and currently there were, no plans to consider options for community work while living at the facility.

15. ISP action plans failed to describe opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet identified needs. Several individuals did not have Daily Schedules and most individuals were not observed to be functionally engaged during the majority of Monitoring Team observations.

16. ISP action plans were not developed to address any identified barriers to achieving goals. For example:

- For Individual #65, there was no action plan to address substance abuse.
- It was positive that the IDT identified behavioral barriers to community integration and community living, but the referral to the behavioral health services department in this regard was not responded to for many months (e.g., for Individual #65).

During the week after the onsite review, the Monitoring Teams shared concerns about Individual #65 with the State, including the need for treatment related to long-standing alcoholism. In its response, the State wrote, "Individual #65 was seen by Behavioral Health Solutions of South Texas for a complete substance abuse assessment on 8/19/15 at 8:00 am. Preliminary findings show that he will need additional counseling sessions, at one session per week for 12 weeks. Individual #65 will then be reevaluated to determine if additional sessions are needed. Initial sessions will evaluate his competency to determine specific topics which will be useful to him in future sessions. Counselor also recommends that family attendance may be required to discuss needed community supports for Individual #65."

17. For the most part, ISPs did not include collection of enough or the right types of data to make decisions regarding the efficacy of supports. IHCP goals/objectives and interventions were not measurable. IHCPs and many other action plans were written as staff actions without specific criteria and many action plans were stated as "will have opportunities" with little additional information as to how often opportunities would be presented.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Compliance rating:

#	Indicator	Score
18	The ISP included a description of the individual's preference for where to live and	17%

	how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	1/6
19	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	N/A
20	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6
21	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6
22	The determination was based on a thorough examination of living options.	0% 0/6
23	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	0% 0/6
24	For annual ISP meetings observed, a list of obstacles to referral was identified.	N/A
25	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6
26	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles.	N/A
27	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	0% 0/6
28	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	0% 0/1

Comments:

18. Only one of six ISPs included a description of the individual's preference (Individual #65) and how that was determined. The remainder indicated that the individual's preference was unknown.

20. For all individuals, some, but not all, assessments included a clear statement from the professional who wrote the assessment. The FSA did not make a recommendation for any of the individuals.

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

22. None of the individuals had a thorough examination of living options based upon their preferences, needs and strengths.

25. ISPs did not identify a thorough and comprehensive list of obstacles to referral in a manner that would allow relevant and measurable goals to address the obstacle to be developed.

- For Individual #92, Individual #112, and Individual #98, the only obstacle identified was funding issues; this did not address individual lack of awareness and other concerns noted in the ISP and assessments.
- For Individual #97, only behavioral/psychiatric barriers were identified; the ISP did not address issues of LAR choice and individual lack of awareness.

26. Action plans to address barriers were not consistently individualized or measurable. There were no action plans to address individual awareness for the five individuals whose preferences were identified as unknown.

28. One individual, Individual #65, had been referred, but the overall lack of assessment of his needs resulted in action plans that were not appropriate for developing a community living option that would promote health and safety.

During the week after the onsite review, the Monitoring Teams shared concerns about Individual #65 with

the State, including the need to ensure that any transition plan consider his needs. A meeting was scheduled for the subsequent week for Individual #65, his parents, facility staff, and provider staff to determine if his needs could be met in the offered community living setting. However, the facility did not itself yet understand the nature and extent of his actual needs and risks, particularly in the areas of health care and behavioral health, or have adequate plans in place to address them. It is imperative these needs and risks be accurately identified for an appropriate community living plan to be developed that provides the necessary supports for his health and safety.

The Monitoring Team heard suggestions that perhaps Individual #65's community referral should be rescinded, but this is not necessarily the logical response. Individual #65 was eager to live in the community and there he would have access to various and more appropriate supports that the facility is unable to provide, such as employment. Thus, although the referral and transition process for Individual #65 may be lengthier than for other individuals, this should not be viewed as a barrier to the referral itself.

In its response, the State wrote, "Currently there is only one provider in Edinburg (Hidalgo County) that was selected by the family. However the provider cannot provide the necessary supports for his health and safety. An ISPA to address this specific issue will be held on 8/21/15 with the HCS provider and family."

Outcome 5: The individual participates in informed decision-making to the fullest extent possible.

Compliance rating:

#	Indicator	Score
29	The individual made his/her own choices and decisions to the greatest extent possible.	0% 0/6
30	Supports needed for informed decision-making were identified through a strengths-based and individualized assessment of functional decision-making capacity.	0% 0/6
31	If the individual needed assistance with decision-making, he or she was prioritized by the facility for assistance in obtaining an LAR.	100% 3/3
32	Individualized ISP action plans were developed to address the identified strengths, needs, and barriers related to informed decision-making.	0% 0/6

Comments:

29. There were minimal choice-making opportunities or action plans to increase decision-making capacity.

30. A strengths-based and individualized assessment to help guide the IDT to provide supports in this regard was not yet in place.

31. The facility was consistently prioritizing individuals for assistance in decision-making.

32. Individualized ISP action plans were not developed and consistently implemented to address the identified strengths, needs, and barriers related to informed decision-making for any of the individuals.

Outcome 6: Individuals' ISPs are current and are developed by an appropriately constituted IDT.

Compliance rating:

#	Indicator	Score
33	The ISP was revised at least annually.	100% 4/4
34	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 2/2
35	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6
36	The individual participated in the planning process and was knowledgeable of the	67%

	personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	4/6
37	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6
<p>Comments:</p> <p>33. ISPs were routinely updated at least annually.</p> <p>34. For two new admissions, Individual #92 and Individual #112, ISPs were completed within 30 days of admission.</p> <p>35. None of the ISPs had all required components of the ISPs implemented on a timely basis.</p> <p>36. Four of six individuals attended their ISP meetings.</p> <p>37. There were often members of the IDT not present at the ISP or relevant ISP meetings who should have participated based on the individuals' needs:</p> <ul style="list-style-type: none"> • For Individual #112, the BCBA was not present at ISPA in which target behavior of putting inedibles in mouth was discussed as significant concern. • For Individual #98, the OT/PT did not participate in the ISP despite falls and use of helmet. • For Individual #97, the OT/PT did not participate in the ISP despite 12 falls in the preceding year and a high risk rating for falls. <p>Also of note for this indicator, QIDPs were not consistently familiar with the needs of individuals.</p> <p>At the Monitors' exit while onsite, and during the week after the onsite review, the Monitoring Teams reported that the facility did not have in place an IDT process that was competent to adequately address the needs of the individuals. There appeared to be insufficient expertise with interdisciplinary facilitation and planning in the QIDP Department to ensure that complex issues are examined thoroughly and in a true interdisciplinary manner.</p> <p>Regarding Individual #65, senior management should take an active role in ensuring the required actions for his care occur, as well as providing support and technical assistance to move the process forward. The State responded that two state office staff were in attendance via conference call for the Individual #65's ISPA on 8/19/15. Moreover, all QIDPs, Nurse Case Managers and QA Coordinators were scheduled to attend the regional ISP Training the last week of August 2015. State office was scheduled to conduct onsite general IDT Training during the second week of September 2015.</p>		

Outcome 7: ISP assessments are completed as per the individuals' needs.		
Compliance rating:		
#	Indicator	Score
38	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	20% 1/5
39	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6
<p>Comments: Monitoring of the timeliness, content, and quality of the various assessments for the individual's ISP are reported in those clinical services sections of this report.</p> <p>38. The facility did not consistently implement the ISP Preparation meeting process in which the IDT is to consider what assessments would be needed for the annual meeting. For Individual #98, an ISP Preparation meeting was held during the onsite visit and the IDT did make this consideration. For the remaining four individuals for whom an annual ISP meeting had been held prior to the onsite visit, no ISP Preparation meeting was held.</p>		

39. For all six individuals, there were assessments that were either not completed on time or did not thoroughly address the individuals' needs, or both. Examples included:

- For Individual #112, whose recent ISP annual meeting was held on 7/23/15, most assessments used were from before he received a PEG and, therefore, did not reflect his current status.
- For Individual #92, some assessments were not completed prior to her 30-day ISP meeting (RN, FSA, and PSI). The vocational assessment was comprised primarily of a completed checklist, but reflected no actual assessment of needs.
- For Individual #97, the MD, RN, and FSA assessments were not present prior to the annual meeting. Again, the vocational assessment consisted of only a checklist, with no actual assessment of needs or recommendations.

Outcome 8: Individuals' progress is reviewed and supports and services are revised as needed.

Compliance rating:

#	Indicator	Score
40	The IDT reviewed and revised the ISP as needed.	0% 0/6
41	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6

Comments:

40. Overall, the IDTs did not meet consistently as required by policy to review and revise the ISP as needed. Examples included:

- Lack of progress and/or regression in skill acquisition and other action plans were not consistently addressed for the individuals.
- Lack of implementation of ISP action plans was not consistently addressed for the individuals.
- ISPA's were not held as required for Individual #97 related to falls.

41. QIDPs' knowledge of individuals' preferences, strengths, and needs varied, but overall there was a significant deficit in this area. QIDPs had not taken action to ensure the individual received required monitoring/review and revision of treatments, services, and supports (as indicated throughout the Monitoring Team's comments in this section). The Monitoring Team found the two current QIDPs to be very enthusiastic and sincere, but they were still inexperienced and not consistently knowledgeable about providing services and supports to the individuals assigned to them. The overall facilitation of the IDT process was marred by a variety of concerns, including:

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

Outcome 1 – Individuals at-risk conditions are properly identified.

Compliance rating:

#	Indicator	Score
a.	The individual's risk rating is accurate:	
	i. The IDT uses supporting clinical data when determining risks levels.	33% 6/18
	ii. The IDT uses the risk guidelines in determining the risk rating.	89% 16/18
	iii. The IDT provides justification for exceptions to the guidelines.	0% 0/2

b.	The individual's risks are identified timely, including:	
	i. The IRRF is completed within 30 days for newly-admitted individuals.	100% 1/1
	ii. The IRRF is updated at least annually.	88% 7/8
	iii. The IRRF is updated within no more than five days when a change of status occurs.	0% 0/18
<p>Comments: For nine individuals, the Monitoring Team reviewed a total of 18 sections of IRRFs addressing specific risk areas (i.e., Individual #112 – aspiration, and cardiac disease; Individual #65 – gastrointestinal problems, and fluid imbalance; Individual #92 – dental, and weight; Individual #19 – UTIs, and other: pain; Individual #2 - dental, and polypharmacy/side effects; Individual #138 – constipation/bowel obstruction, and skin integrity; Individual #145 – respiratory compromise, and behavioral health; Individual #62 – skin integrity, and weight; and Individual #126 – gastrointestinal problems, and other: pain).</p> <p>a.i through a.iii. The IDTs that effectively used supporting clinical data when determining a risk level were those for Individual #92 – weight, Individual #2 – dental, Individual #145 – respiratory compromise, Individual #62 – weight, and Individual #126 – gastrointestinal problems, and other: pain. The IDT that did not use the risk guidelines was the one for Individual #19 – UTIs, and other: pain. The IRRF for Individual #19 – UTIs, and other: pain also did not include the IDT's justification for not adhering to the risk guidelines when they chose a different rating than what the guidelines suggested.</p> <p>b. Individual #92 was newly admitted, and her IRRF was completed within 30 days of her admission. For the individuals the Monitoring Team reviewed, the IDTs generally updated the IRRFs at least annually. The exception was Individual #112. It was concerning that 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.</p>		

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
4	The individual has goals/objectives related to psychiatric status.	0% 0/9
5	The psychiatric goals/objectives are measurable.	11% 1/9
6	The goals/objectives are based upon the individual's assessment.	0% 0/9
7	Reliable and valid data are available that report/summarize the individual's status and progress.	11% 1/9
<p>Comments:</p> <p>4-7. Psychiatry-related personal goals for individuals were related to the reduction of problematic behaviors, such as self-injury and aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. One individual, Individual #77, had goals that were measurable, though they did not relate to the psychiatric status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined.</p> <p>The Monitoring Team engaged in much productive discussion with the facility's clinical director who also was a psychiatrist. He was very aware of the need for these types of personal goals and had already made quite a bit of progress in identifying (and applying) some standardized measures of psychiatric disorders</p>		

as well as moving towards working with behavioral health services and residential services to collect data on overt behaviors that the psychiatrist would like to have recorded in order to make a determination on the status of individuals' unique psychiatric status and symptom presentation.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Compliance rating:

#	Indicator	Score
12	The individual has a CPE.	89% 8/9
13	CPE is formatted as per Appendix B	89% 8/9
14	CPE content is comprehensive.	89% 8/9
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/3
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.	78% 7/9

Comments:

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

Compliance rating:

#	Indicator	Score
17	Status and treatment document was updated within past 12 months.	100% 2/2
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	100% 2/2
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP.	0% 0/9
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	56% 5/9
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	11% 1/9

Comments:

This outcome covers the annual updates that are prepared specifically for the ISP.

17. Given that CPEs were recently completed (or completely re-done), only two individuals were scored for this indicator (Individual #36, Individual #97).

18. The Monitoring Team scores 16 aspects of the annual document. All were complete for the two individuals included in this indicator.

19. There were issues with the timing of psychiatric documentation relative to the date of the scheduled ISP. This was, in part, due to draft documentation being prepared prior to the meeting (10 or more days prior to the ISP) and then it being finalized after, or at, the meeting. The Monitoring Team and the clinical director discussed adding a draft date on the documentation; this would be sufficient to meet criterion with this indicator.

21. There was evidence of the psychiatrist's participation in five of the ISP meetings. This was good to see, however, there was a need for improvement with regard to the documentation of this discussion to include

the rationale for determining that the proposed psychiatric treatment represented the least intrusive and most positive interventions, the integration of behavioral and psychiatric approaches, the signs and symptoms monitored to ensure that the interventions are effective, the incorporation of data into the discussion that would support the conclusions of these discussions, and a discussion of both the potential and realized side effects of the medication. There was an overall need for improvement in the ISP regarding the integration of psychiatry with other clinical disciplines, especially at this facility where the psychiatrist worked closely with teams and with other disciplines.

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

Compliance rating:

#	Indicator	Score
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	N/A

Comments:
22. None of the individuals reviewed had a PSP.

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

Compliance rating:

#	Indicator	Score
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	78% 7/9
29	The written information provided to individual and to the guardian was adequate and understandable.	89% 8/9
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	0% 0/9
32	HRC review was obtained prior to implementation and annually.	11% 1/9

Comments:

28. Consents were completed for all but two of the individuals. For Individual #97, only one consent was dated within the previous year; the others were dated in 2013. For Individual #112, there were no consents for Benadryl, which was prescribed at admission or, for the currently prescribed medication, Ambien.

30-31. While the risk versus benefit discussion was not included in the consent documentation, there was detailed documentation included in the annual assessment. Similar issues were noted regarding alternate and non-pharmacological interventions that were considered. A clerical change should be made in order to meet criterion with these two indicators.

32. HRC documentation was only available for Individual #97. HRC review is required prior to the initiation of medication and annually.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.		
Compliance rating:		
#	Indicator	Score
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 13/13
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 9/9
3	The psychological/behavioral goals/objectives are measurable.	100% 9/9
4	The goals/objectives were based upon the individual’s assessments.	89% 8/9
5	Reliable and valid data are available that report/summarize the individual’s status and progress.	0% 0/9
<p>Comments:</p> <p>1. Of the 16 individuals reviewed by both Monitoring Teams, all 13 who required PBSPs had PBSPs.</p> <p>2-3. All PBSPs had objective goals and all of them were measurable.</p> <p>4. The goals/objectives in the PBSP were consistent with the information found in the functional assessments for eight of the nine individuals. In the exception (Individual #112), the PBSP included behavioral objectives that were higher than his baseline rates for aggression and destruction.</p> <p>5. It was encouraging to see that all nine PBSPs had established goals for the collection of PBSP data reliability (interobserver agreement). None of the PBSPs, however, had reliability measures that achieved both the frequency (once a quarter) and level (80%). Furthermore, DSPs were supposed to record data on paper when it occurred, but only one DSP had something written down. Typically, DSPs recorded data at the end of the 12-hour shift. The behavioral health services staff also indicated they did not have confidence in the data. Therefore, all PBSP data were judged as unreliable. In order to demonstrate that PBSP target and replacement behaviors are reliable, the facility needs to collect interobserver agreement and data collection reliability at the frequency and level established by the facility.</p>		

Outcome 3 - Behavioral health annual and the FA.		
Compliance rating:		
#	Indicator	Score
11	The individual has a current, and complete annual behavioral health update.	33% 3/9
12	The functional assessment is current (within the past 12 months).	78% 7/9
13	The functional assessment is complete.	67% 6/9
<p>Comments:</p> <p>11. All individuals had annual behavioral health assessments. Only three, however, were judged to be complete and timely. Some were complete, but more than 12 months old (e.g., Individual #97), others were current, but not complete (e.g., Individual #36). To be rated as complete, all annual behavioral health assessments need to include:</p> <ul style="list-style-type: none"> • an assessment or review of intellectual ability 		

- an assessment or review of adaptive ability
- a screening or review of psychiatric and behavioral status
- a review of personal history
- a review of medical status

12. Seven of nine functional assessments were current. Individual #98's functional assessment was dated in the last 12 months, however, the indirect assessment was dated as more than 12 months old. Individual #44's functional assessment was dated 4/24/14.

13. The majority of the functional assessments were complete and contained all of the required components. In three of the functional assessments (Individual #98, Individual #34, Individual #104), however, the direct assessment did not capture target behaviors and, therefore, was not particularly useful in identifying potential antecedent and consequent events associated with the targeted behaviors.

Outcome 4 – Quality of PBSP		
14	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	56% 5/9
15	The PBSP was current (within the past 12 months).	89% 8/9
16	The PBSP was complete, meeting all requirements for content and quality.	78% 7/9
<p>Comments:</p> <p>14. Data indicated that Individual #97's, Individual #77's, Individual #65's, and Individual #98's PBSPs were implemented more than 14 days after attaining the necessary consents.</p> <p>15. Eighty-nine percent of the PBSPs were current. The exception was Individual #44's.</p> <p>16. The Monitoring Team reviews 13 components in the evaluation of an effective behavior support plan. Seven of the nine PBSPs (78%) were scored as complete, and the majority of components were found in all PBSPs. Two PBSPs (Individual #77, Individual #112) were rated as incomplete because they did not include clear instructions to staff to reinforce the replacement behaviors when they occurred.</p>		

Outcome 7 – Counseling		
Compliance rating:		
#	Indicator	Score
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A
<p>Comments:</p> <p>24-25. None of the individuals reviewed by the Monitoring Team were reported to require or receive counseling/psychotherapy.</p>		

Medical

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	100% 1/1

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.	11% 1/9
c.	Individual has quarterly reviews for the three quarters in which an annual review has not been completed.	11% 1/9
d.	Individual receives quality AMA.	0% 0/9
e.	Individual's diagnoses are justified by appropriate criteria.	94% 17/18
f.	Individual receives quality quarterly medical reviews.	11% 1/9

Comments: a. through c. Of the nine individuals reviewed (i.e., Individual #62, Individual #145, Individual #92, Individual #2, Individual #112, Individual #126, Individual #19, Individual #138, and Individual #65), Individual #92 was newly admitted. Her initial medical assessment was completed on the same day as her admission, and was up-to-date at the time of the Monitoring Team's review. Based on documentation submitted, the following individuals were overdue for annual medical assessments: Individual #145, Individual #112, Individual #138, and Individual #65. In the six months prior to his death in March 2015, Individual #126 had timely quarterly medical reviews.

d. For all of the individuals reviewed, four or more required components of annual medical assessments were missing or incomplete. On a positive note, all included allergies or severe side effects of medications, and interval histories, and most included, as applicable, social/smoking histories, past medical histories, and complete physical exams with vital signs. Areas that were problematic included pre-natal histories; family history; childhood illnesses; lists of medications with dosages at the time of the AMA; review of associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable; pertinent laboratory information; updated active problem lists; and plans of care for each active medical problem, when appropriate.

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

- For Individual #138, the AMA stated propranol was prescribed for hypertension. Pharmacy documented that the use was for psychiatric illness. There was no evidence to support the diagnosis of hypertension.

f. For the nine individuals reviewed, the Monitoring Team reviewed the last quarterly medical review, but also needed the previous one to reference. For a number of individuals, no 2015 quarterly review was available during the Monitoring Team's August 2015 review. The only individual for whom the quarterly review included the required content was Individual #126.

Outcome 7 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.

Compliance rating:

#	Indicator	Score
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.	33% 6/18

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #62 – constipation/bowel obstruction, and cardiac disease; Individual #145 – seizures, and constipation/bowel obstruction; Individual #92 – seizures, and dental; Individual #2 – cardiac disease, and gastrointestinal problems; Individual #112 – cardiac disease, and respiratory compromise; Individual #126 – aspiration, and seizures; Individual #19 – seizures, and osteoporosis; Individual #138 – osteoporosis, and other: metabolic syndrome; and Individual #65 – gastrointestinal

problems, and other: polydipsia and borderline high serum sodium).

The ISPs/IHCPs that sufficiently identified the medical care necessary to address the individual's chronic care or at-risk condition were those for Individual #62 cardiac disease; Individual #92 – dental; Individual #2 – cardiac disease, and gastrointestinal problems; and Individual #19 – seizures, and osteoporosis.

Dental

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

Compliance rating:

#	Indicator	Score
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% 0/2
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	29% 2/7
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	0% 0/9
b.	Individual receives a quality dental examination.	11% 1/9
c.	Individual receives a quality dental summary.	0% 0/9

Comments: a. For the individuals reviewed, the dental examinations that were completed timely were for Individual #138, and Individual #19. None of the individuals reviewed had dental summaries.

b. The dental exam that included all of the required elements was the one for Individual #126. For the remaining individuals, two or more elements were missing or incomplete. On a positive note, most dental exams reviewed documented, as applicable, a description of the individual's cooperation, information about oral cancer screening, an oral hygiene rating completed prior to treatment, caries risk and periodontal risk, a description of treatment provided, and the recall frequency. Missing from three or more dental exams was, as applicable, information about sedation use, information about the individual's last x-rays and the type of x-rays, periodontal charting, a description of periodontal condition, an odontogram, the number of teeth present/missing, and treatment plans.

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

The Facility submitted a series of dental IPN entries. The dentist had not completed these entries. The Registered Dental Hygienist (RDH), who was not present at the dental office and did not participate in the care, made IPN entries based on the dental exam form (template) that the dentist submitted. The IPN entries often included information that was not documented on the dental exam form or in actual treatment notes. The RDH reported that she included information found from other sources, such as billing forms. Thus, the IPN entries were not documentation from the treating dentist, but were summaries of information the RDH gathered. The accuracy of this information could not be determined.

The RDH also made IPN entries that provided historical information. For some individuals, IPN entries

were found that documented the last date of x-rays and the number of missing teeth. For other individuals, this was noted in the IRRF. This might have been an effort to document required information. However, the information on the individuals' dental status was not presented in an organized and cogent manner. The annual dental exam/summary templates require the dentist to document this relevant information, but the community dentist was not doing it. The annual dental exam template also included a section related to the need for dentures/partials, but it was blank in all of the documents reviewed. Additionally, the dentist determined that every person reviewed had no need for suction tooth brushing, even when enteral tubes were used for nutritional support.

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

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

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.		
Compliance rating:		
#	Indicator	Score
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.	0% 0/1
	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.	44% 4/9
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	89% 8/9
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18
c.	If during the review period, the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	0% 0/18
<p>Comments: a.ii. through a.iii. Individual #92 was newly admitted, but did not have a timely initial comprehensive nursing assessment. Individual #65, Individual #19, Individual #138, and Individual #145 had timely annual comprehensive nursing reviews and physical assessments. Individual #62 did not have timely quarterly nursing record reviews and physical assessments.</p> <p>b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #112 – aspiration, and cardiac disease; Individual #65 – gastrointestinal problems, and fluid imbalance; Individual #92 – dental, and weight; Individual #19 – UTIs, and other: pain; Individual #2 – dental, and polypharmacy/side effects; Individual #138 – constipation/bowel obstruction, and skin integrity; Individual #145 – respiratory compromise, and behavioral health; Individual #62 – skin integrity, and weight; and Individual #126 – gastrointestinal problems, and other: pain). For the risks reviewed, the</p>		

annual comprehensive nursing assessments did not contain reviews of them that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g. skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible.

c. In a number of instances, information/data was incomplete, so it could not be determined if changes of status had occurred. When individuals reviewed had changes in status, nursing assessments were not completed in accordance with nursing protocols or current standards of practice. The following provide some examples of problems noted:

- For Individual #65's gastrointestinal problems, the Facility's documentation system made it difficult to determine if or how his issues were being tracked, and whether or not he was getting better or worse. Apparently, though, the vomiting episodes were so frequent that the enamel on his remaining teeth (i.e., most have been extracted with more extractions scheduled) was eroding off.
- Individual #19 had recurring UTIs. She was fed by G-tube and used a wheelchair. For check and change, the staff reported that during the day, they did not move her into her bed to determine if she was wet, but rather just looked into her briefs. Based on her positioning and her posture, it would be impossible to determine if she was wet or soiled using the method that the staff demonstrated to Monitoring Team members during the onsite review. In addition, she received her tube feeding during the day, and would very likely urinate sometime during the day. However, the staff indicated that she was usually dry, using their method of checking, and so she did not usually have a change of her brief until evening time. On a typical day, she was in her wheelchair for six to eight hours, and no documentation was found to show that she was repositioned out of the wheelchair. Based on a urinalysis showing e coli when she had a UTI, it was evident that she was not being promptly changed when she was soiled. When the Monitoring Team brought these issues to the attention of the Chief Nurse Executive and Nursing Operations Office, they stated that the RN Case Manager was not aware that Individual #19 was in the same position for hours, and was not being adequately checked for incontinence during the day. They could not produce documentation that she was in different positions during the day.
- Individual #138 had a number of red areas, bruises, and skin issues. However, nursing assessments were consistently incomplete, and the skin issues were not regularly assessed to determine if healing was progressing.
- On 2/17/15, Individual #145, who was prescribed Clozaril, was noted to be staggering and moving slowly. Nursing staff did not adequately assess him in that they completed no neuro checks, skin assessment, or mental status. He needed a head-to-toe assessment, but was sent to the ED for a possible drug reaction.

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.

Compliance rating:

#	Indicator	Score
a.	The individual's ISP, including the integrated health care plan (IHCP), includes nursing interventions that address the chronic/at-risk condition.	0% 0/18
b.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18
c.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18
d.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18
e.	The IHCP action steps support the goal/objective.	0% 0/18

f.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18
g.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18
<p>Comments: a. through f. Problems seen across IHCPs were: missing nursing interventions to address the chronic/at-risk condition; a lack of individualization of nursing protocols to address the individuals' specific health care needs; a lack of focus on preventative measures; a lack of measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working); a lack of action steps that supported the goal/objective; a lack of specific clinical indicators to be monitored; and lack of identification of the frequency for monitoring of the individuals' health risks.</p> <p>Some examples of problems included:</p> <ul style="list-style-type: none"> • At the time of the Monitoring Team's onsite review, Individual #112, who was at high risk for aspiration, had been back at the Facility for three weeks after being hospitalized and having a G-Tube placed. However, his ISP/IHCP still had not been updated to reflect his significant change in status, going from oral intake to receiving nothing by mouth and being fed by G-tube. The IHCP that Facility staff gave to the Monitoring Team on Wednesday of the onsite review week did not meet his needs. For example, it did not note he was to receive nothing by mouth and had a G-tube. In addition, despite the fact that he had been hospitalized a total of three times since February 2015 for aspiration, the goal stated: "will have fewer episodes of coughing up phlegm." • Similarly, Individual #112 was at high risk for cardiac issues. The IHCP in the record was from 5/8/15, and the only goal listed was: "will not have more than a 5 lb. weight gain in any given month for the next 6 months." The IHCP was not updated to reflect his congestive heart failure, atrial fibrillation, and current status of him being in a wheelchair due to racing heart rates, at times, when he walked. During the onsite review, the Monitoring Teams had a number of conversations with Facility staff about concerns regarding problems with his plans of care. However, at the time of the review, the IDT had not developed IHCPs that met his clinical needs, which was of significant concern for this individual who had experienced a major change of status. • For Individual #62, weight was rated as high risk on the IRRF, but was not included in the IHCP. In addition, fluid imbalance (high), osteoporosis (medium), falls (medium), fractures (medium), infections (high), urinary tract infection (UTI) (high), and behavior (medium) were not included in the IHCP for this individual. • For Individual #126, the IHCP stated: "All risk factors" with a goal to "reduce the number of hospitalizations to none within the next six months." There were no specific risks listed on the IHCP itself to identify what specific risks he had. The ISP date was written as 5/20/14, but the implementation date on the IHCP was 12/11/14. It was a Change of Status IHCP, but the Facility did not provide the original one, if there was one. With regard to the two areas the Monitoring Team specifically reviewed, the IDT included no interventions in the IHCP to address his gastrointestinal issues or pain. 		

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns are referred to the Physical and Nutritional Management Team (PNMT) as needed, and receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.		
Compliance rating:		
#	Indicator	Score
a.	If individual has PNM issues, individual is referred to or reviewed by the PNMT as appropriate.	50% 3/6
b.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	20% 1/5
c.	The PNMT review is completed within five days of the referral, but sooner if	0%

	clinically indicated.	0/6
d.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/6
e.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	67% 4/6
f.	As appropriate, a Registered Nurse (RN) Post Hospitalization Assessment is completed, and the PNMT discusses the results.	20% 1/5
g.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6
h.	If a PNMT review is required, the individual's PNMT review at a minimum discusses: <ul style="list-style-type: none"> • Presenting problem; • Pertinent diagnoses; • Pertinent medical history; • Current risk ratings; • Current health and physical status; • Potential impact on and relevance of impact on PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan. 	0% 0/3
i.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5
<p>Comments: a. through d. Of the nine individuals reviewed, six individuals had qualifying events (i.e., Individual #112, Individual #65, Individual #19, Individual #62, Individual #145, and Individual #126). Three of the six individuals were referred to and/or reviewed by the PNMT, including Individual #19, Individual #62, and Individual #126. Timeliness of referral was not assessed for Individual #126, because the referral occurred in 2014. None of the individuals' PNMT assessments were initiated within five days of the IDT's referral of the individual to the PNMT or occurrence of a qualifying event (i.e., if the IDT did not refer, the PNMT should have initiated a self-referral), and completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances.</p> <p>e. The PNMT conducted comprehensive assessments of the following individuals: Individual #112, Individual #19, Individual #62, and Individual #126. Individual #65 should have had a comprehensive assessment to address aspiration pneumonia, emesis, and polydipsia, but was not referred to the PNMT until the week the Monitoring Teams were on site. Based on Individual #145's 14-pound unplanned weight loss in three months in 2014 and continuing weight loss in 2015, the PNMT should have at least reviewed him.</p> <p>f. This indicator was not applicable for Individual #145. Individual #126 had a timely PNMT RN Post-Hospitalization Review conducted, and the PNMT discussed the results. For the other four individuals, PNMT RN Post Hospitalization Reviews were not completed and/or submitted, and/or evidence was not available to show the PNMT reviewed them.</p> <p>g. The disciplines needed to address the identified issues participated in Individual #126's assessment.</p> <p>h. Individuals that did not have PNMT reviews that included the required elements were Individual #65, Individual #19, and Individual #145.</p> <p>i. Individual #65 should have had a PNMT comprehensive assessment, but did not. For the remaining four individuals for whom the PNMT completed assessments, problems were noted with all of them. The problems varied across assessments. On a positive note, most of the assessments included:</p> <ul style="list-style-type: none"> • Evidence of observation of the individual's supports at his/her home and day/work programs. 		

The following components were problematic in two or more assessments:

- Presenting problem;
- Discussion of pertinent diagnoses, pertinent medical history, and current health status, including relevance of impact on PNM needs;
- Review of the current 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;
- Assessment of current physical status;
- Discussion as to whether existing supports were effective or appropriate;
- Identification of the potential causes of the individual's physical and nutritional management problems;
- Recommendations, including rationale, for physical and nutritional interventions; and
- Recommendations for measurable goals/objectives, as well as indicators and thresholds.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.

Compliance rating:

#	Indicator	Score
a.	The individual has an ISP/IHCP that sufficiently addresses the individual's identified PNM needs as presented in the PNMT assessment/review or Physical and Nutritional Management Plan (PNMP).	6% 1/17
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	29% 5/17
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/9
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	12% 2/17
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/17
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/17
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	24% 4/17

Comments: The Monitoring Team reviewed 17 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT were responsible for developing. These included IHCPs related to: aspiration, and weight for Individual #112; aspiration, and choking for Individual #65; choking, and weight for Individual #145; aspiration, and falls for Individual #126; choking for Individual #92; choking, and aspiration for Individual #2; aspiration, and circulatory for Individual #19; skin integrity, and weight for Individual #62; and choking, and falls for Individual #138.

a. ISPs/IHCPs reviewed generally did not sufficiently address individuals' PNM needs. The exception was Individual #145's IHCP related to choking.

b. ISPs/IHCPs often did not include preventative measures to minimize the individual's condition of risk. Exceptions were those for choking for Individual #65; skin integrity for Individual #62; choking, and weight for Individual #145; and choking for Individual #138.

c. The nine individuals reviewed had PNMPs. All of the PNMPs included some, but not all of the necessary components.

d. Overall, many action steps, including strategies and interventions were missing from IHCPs, and the etiology of the issue often was not addressed. Those that did include necessary action steps were those for choking, and weight for Individual #145.

e. The IHCP that identified the necessary clinical indicators was the one for weight for Individual #145.

g. At times, IHCPs did not include effectiveness monitoring, and in other instances, it was mentioned, but with no clear due dates or frequency, the frequency was not consistent with the individual's level of risk, or what the monitoring was to entail was unclear or was not in line with the individual's needs. The exceptions were for aspiration, and weight for Individual #112; and aspiration, and choking for Individual #65.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.		
Compliance rating:		
#	Indicator	Score
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.	0% 0/1
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	22% 2/9
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	0% 0/9
c.	Individual receives quality screening, including the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> a. Vision, hearing, and other sensory input; b. Posture; c. Strength; d. Range of movement; e. Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment. 	0% 0/2
d.	Individual receives quality Comprehensive Assessment.	0% 0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/8
Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #62, Individual #145, Individual #92, Individual #2, Individual #112, Individual #126, Individual #19, Individual #138, and Individual #65), Individual #92 was newly admitted. The individuals that had timely OT/PT assessments were Individual		

#138, and Individual #2.

c. Individual #145 and Individual #138 had screenings completed. However, both had PNMPs and needed mealtime supports, so should have had comprehensive assessments every five years with annual updates. The screenings provided no justification for not completing assessments.

d. and e. The following individual had a comprehensive assessment: Individual #92. The remaining individuals had or should have had updates. For a number of individuals (e.g., Individual #112, Individual #65, Individual #19, and Individual #62), an OT was not available at the Facility when “updates” were completed, and the updates were simply the previous assessment with a few sentences added, which did not meet individuals’ needs. In all assessments and updates reviewed, numerous key components were not sufficient to address the individual’s strengths, needs, and preferences. Based on the problems identified in the assessment and updates reviewed, moving forward, the Facility should focus on ensuring that assessments include and updates provide current information on the following:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual’s preferences and strengths are 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.

Compliance rating:

#	Indicator	Score
a.	The individual’s ISP includes a description of how the individual functions from an OT/PT perspective.	11% 1/9
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.	56% 5/9
c.	Individual’s ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/6
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	0% 0/2

implementation.
<p>Comments: a. For the individuals reviewed, the ISP that provided a good description of the individual's functioning from an OT/PT perspective was the one for Individual #126.</p> <p>b. The IDTs that reviewed and updated PNMPs and/or Positioning Schedules at least annually, and as the individual's needs dictated were those for Individual #65, Individual #62, Individual #2, Individual #92, and Individual #126.</p> <p>c. This indicator was not applicable for Individual #65, Individual #145, and Individual #2.</p> <p>d. Individual #112 experienced a significant change in status, but no direct therapy was initiated. Reportedly, the PT did not receive the doctor's order. Physical therapy was initiated during the week of the onsite review after discussion with the Monitoring Team member. No ISPAs were submitted.</p> <p>Individual #19 also experienced a significant change in status, and was not provided needed therapy services. Prior to April 2015, she was walking and transferring, but then began using the wheelchair full-time and must be transferred using a mechanical lift. At the time of the change in status, there was no evidence of an OT/PT assessment, and no assessment occurred until the annual update was conducted in late June. Although direct OT/PT was indicated, there was no evidence that it was provided at the time the change in status was initially identified. No ISPA was submitted for initiating therapy outside the ISP, and no ISP was submitted.</p>

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives timely communication screening and/or assessment:	
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	89% 8/9
b.	Individual receives assessment in accordance with their individualized needs related to communication.	78% 7/9
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: <ul style="list-style-type: none"> • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: <ul style="list-style-type: none"> a. Vision, hearing, and other sensory input; b. 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- 	50% 2/4

	based]; and <ul style="list-style-type: none"> • Recommendations, including need for assessment. 	
d.	Individual receives quality Comprehensive Assessment.	0% 0/3
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2
<p>Comments: a. and b. Of the nine individuals reviewed (i.e., Individual #62, Individual #145, Individual #92, Individual #2, Individual #112, Individual #126, Individual #19, Individual #138, and Individual #65), Individual #92 was newly admitted. Based on the documentation the Facility provided, the following individual did not have a timely communication screening, assessment, or updates completed: Individual #112 (no screening completed after hospitalizations to determine if further assessment was warranted).</p> <p>c. Individual #138 and Individual #145 had communication screenings that included the required components. As noted above, Individual #112 did not have a screening completed after his hospitalizations. Individual #65's screening did not identify the re-assessment/screening schedule.</p> <p>d. and e. Individual #62, Individual #19, and Individual #92 had communication assessments. Individual #2, and Individual #126 had communication updates. Problems varied across assessments and updates, but in all of them, a number of key components were not sufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the assessments and updates reviewed, moving forward, the Facility should ensure communication assessments and updates address, and/or include updates, as appropriate, regarding:</p> <ul style="list-style-type: none"> • 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; • Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; • 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; • 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; • Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; 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. <p>Of particular concern was the lack of competent assessment of individuals' potential to use AAC devices, including low and high-tech options.</p>		

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.		
Compliance rating:		
#	Indicator	Score
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.	11% 1/9
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual’s non-verbal communication.	0% 0/4
c.	Individual’s ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	0% 0/7
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.	0% 0/1
<p>Comments: a. The ISP for Individual #126 provided a good description of how the individual communicates, and how staff should communicate with him.</p> <p>b. The individuals who had Communication Dictionaries included: Individual #62, Individual #19, Individual #92, and Individual #126.</p> <p>c. The individuals for whom recommended or needed communication interventions, strategies, and programs were not included in their ISPs were Individual #62, Individual #145, Individual #92, Individual #2, Individual #126, Individual #19, and Individual #138.</p> <p>d. For Individual #19, an ISPA meeting should have been held to discuss choice making with a device.</p>		

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.		
Compliance rating:		
#	Indicator	Score
1	The individual has skill acquisition plans.	100% 9/9
2	The SAPs are measurable.	100% 25/25
3	The individual’s SAPs were based on assessment results.	48% 12/25
4	SAPs are practical, functional, and meaningful.	32% 8/25
5	Reliable and valid data are available that report/summarize the individual’s status and progress.	0% 0/25
<p>Comments:</p> <p>1. All nine individuals had skill acquisition plans (SAPs).</p> <p>2. The Monitoring Team chooses three current SAPs for each individual for review. Only two SAPs with data were available for review for Individual #65 and Individual #34 for a total of 25 for this review. All of the SAPs were judged to be measurable.</p>		

3. Forty-eight percent of the SAPs reviewed were clearly based on assessment results. For the others, many did not have documentation that they were based on a demonstrated need or preference (e.g., Individual #44's budgeting SAP), or assessment data suggested the individual already had the skill (e.g., Individual #98's shaking hands SAP).

4. Similarly, only 32% of SAPs were judged to be practical, functional, and meaningful. The SAPs that did not meet criterion for this indicator typically represented a compliance issue rather than a new skill (e.g., Individual #104's engagement SAP), or available assessment information suggested that the individual already demonstrated the skill (e.g., Individual #77's tracing SAP), or there was not any information or rationale why that SAP was chosen (e.g., Individual #65's SAP to repeat the verbal prompt that this is Zyprexa.)

5. None of the 25 SAPs were scored as having reliable data primarily because none of the SAPs had interobserver data to demonstrate that the data were accurate. Additionally, the Monitoring Team's observation of some SAPs (e.g., Individual #112's SAP to turn on the radio) indicated that data were not accurately recorded and, for some SAPs, the available raw data and data in the QIDP monthly report were not consistent (e.g., Individual #97's SAP to apply hand sanitizer). The best way to ensure that SAP data are reliable is to regularly assess interobserver reliability (IOA).

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.

Compliance rating:

#	Indicator	Score
10	The individual has a current FSA, PSI, and vocational assessment.	78% 7/9
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	0% 0/8
12	These assessments included recommendations for skill acquisition.	0% 0/9

Comments:

10-11. Seven of the nine individuals (78%) had current FSAs, PSIs, and vocational assessments. The exceptions were that Individual #112 and Individual #34 missing a PSI. These assessments, however, were not as useful as they could be because none of individuals (there were no data available for Individual #104) had all of these assessments available to the IDT at least 10 days prior to their ISP.

12. Individual #77's FSA and Individual #65's and Individual #36's vocational assessments included a SAP recommendation, however, none of the individuals had both vocational and functional skills assessments that included SAP recommendations.

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

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.		
Compliance rating:		
#	Indicator	Score
20	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	N/A
21	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPA's existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	N/A
22	The minutes from the individual's ISPA meeting reflected: <ol style="list-style-type: none"> 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. 	N/A
23	The minutes from the individual's ISPA meeting reflected: <ol style="list-style-type: none"> 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them. 	N/A
24	Did the minutes from the individual's ISPA meeting reflect: <ol style="list-style-type: none"> 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them? 	N/A
25	The minutes from the individual's ISPA meeting reflected: <ol style="list-style-type: none"> 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. 	N/A
26	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	N/A
27	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	N/A
28	The PBSP was complete.	N/A
29	The crisis intervention plan was complete.	N/A
30	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	N/A
31	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	N/A
Comments: 20-31. None of the individuals reviewed were reported to have been placed in crisis intervention restraints more than three times in any rolling 30-day period. Moreover, there was no individual at Rio Grande State Center who met criterion for inclusion in this outcome. This was good to see.		

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.		
Compliance rating:		
#	Indicator	Score
1	If not receiving psychiatric services, a Reiss was conducted.	0% 0/2
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
<p>Comments:</p> <p>1. For the 16 individuals reviewed by both Monitoring Teams, all but two individuals were receiving psychiatric services. A Reiss screen was not conducted for either of these two individuals (Individual #126, Individual #19). In addition, Individual #112 was admitted 8/4/14 and first saw psychiatry on 11/7/14. A brief IPN was authored 8/8/14, however, a Reiss screen was not performed.</p>		

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
8	The individual is making progress and/or maintaining stability.	0% 0/9
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	89% 8/9
11	Activity and/or revisions to treatment were implemented.	89% 8/9
<p>Comments:</p> <p>8-9. This outcome is concerned with the individual's general clinical status and stability. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators were scored as 0%.</p> <p>That being said, three of the individuals were reported to be doing well psychiatrically (Individual #104, Individual #97, Individual #98). This was based upon anecdotal information in the record, observations by the Monitoring Team, and conversations with facility staff.</p> <p>10-11. Despite the absence of measurable personal goals, it was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.</p>		

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.		
Compliance rating:		
#	Indicator	Score
23	The derivation of the target behaviors was consistent in both the structural/functional behavioral assessment and the psychiatric documentation.	44% 4/9

24	The psychiatrist participated in the development of the PBSP.	100% 9/9
<p>Comments: This outcome relates to the coordination of treatment between psychiatry and behavioral health services.</p> <p>23. The derivations of the target behaviors met criterion for this indicator for Individual #36, Individual #97, Individual #65, and Individual #34. In particular, this was noted for compulsive behaviors and intermittent explosive disorder. For the other individuals, the target symptoms did not correspond with a specific diagnosis.</p> <p>24. It was good to see psychiatrist participation in the development of the PBSP. Moreover, the psychiatrist regularly met with behavioral health clinicians.</p>		

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.		
Compliance rating:		
#	Indicator	Score
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	80% 4/5
26	Frequency was at least annual.	40% 2/5
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	40% 2/5
<p>Comments: This outcome addresses the coordination between psychiatry and neurology. These indicators applied to five of the individuals (Individual #36, Individual #104, Individual #97, Individual #77, Individual #98).</p> <p>25. There was a dedicated section in the psychiatric quarterly notes for contact with neurology that noted if the individual was followed by neurology, if there had been any medication changes by neurology, and/or if any new clinical issues were identified. In general, psychiatry did a good job of documenting the neurological information when it was available. Individual #36 was not scored as meeting criterion because she had not been seen by neurology since 2003.</p> <p>26-27. Individual #77 and Individual #98 had consultation with neurology documented within the past year.</p>		

Outcome 10 – Individuals’ psychiatric treatment is reviewed at quarterly clinics.		
Compliance rating:		
#	Indicator	Score
33	Quarterly reviews were completed quarterly.	78% 7/9
34	Quarterly reviews contained required content.	0% 0/9
35	The individual’s psychiatric clinic, as observed, included the standard components.	100% 3/3
<p>Comments: 33. Seven of the individuals had regularly documented quarterly reviews (at Rio Grande, they were called quarterly psychotropic medication reviews, QPMR, or QMR). Individual #97’s last quarterly was October 2014, and Individual #34’s was April 2015.</p> <p>34. The Monitoring Team looks for nine components to have occurred during the quarterly reviews. Seven of the nine were missing a single component: whether the non-pharmacological interventions</p>		

recommended by the psychiatrist and approved by the IDT were being implemented. In addition, some of the data reported in the documentation was not current. This was due, in part, to the loss of a clerical position within the psychiatry department. To deal with this, the psychiatrist often drew additional data points onto the graphs that were two or three months old so that he had more current information upon which to base treatment decisions.

35. Quarterly psychotropic medication clinics observed by the Monitoring Team were well-attended, included good discussion, and were guided by the psychiatrists' detailed outline that included review of lab values, environmental variables, and so forth.

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

Compliance rating:

#	Indicator	Score
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	100% 9/9

Comments:

36. In general, these assessments were performed in a timely manner and reviewed by the psychiatrist within 15 days. In all cases, the psychiatrist's review was handwritten on the document in lieu of using the electronic program. It should be standard that all psychiatrists utilize the electronic program for review of these assessments.

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

Compliance rating:

#	Indicator	Score
37	Emergency/urgent and follow-up/interim clinics were available if needed.	88% 7/8
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	86% 6/7
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	86% 6/7

Comments:

37-39. At Rio Grande State Center, interim psychiatry appointments were called psychiatry clinics. There was evidence of these clinics being frequently available and regularly provided when an individual was clinically unstable, upon request from the IDT, or as a requested follow-up by the psychiatrist based upon medication changes, health status changes, etc. Documents were generally handwritten and titled as a face-to-face assessment.

The Monitoring Team attended these interim clinics. Attendance was limited to the psychiatrist and one or two direct support professionals. Updated data were not presented. The psychiatrist said he was working to have these interim clinics be more comprehensive as they were in the past.

These indicators applied to all of the individuals except for Individual #112. Criterion was met for all individuals except for Individual #104. While there were some additional clinics, for example 2/18/15, there were notations that he should be seen within 30 days or three weeks, however, this did not occur.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.		
Compliance rating:		
#	Indicator	Score
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 9/9
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A
Comments: 40-42. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment. The facility did not use PEMA.		

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.		
Compliance rating:		
#	Indicator	Score
--	Is this individual receiving medications that meet the polypharmacy definition?	--
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 5/5
45	There is a tapering plan, or rationale for why not.	100% 5/5
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 4/4
Comments: The medication regimens of five of the individuals met the definition of polypharmacy, however, Individual #36 had only recently met the criteria. 44-45. The facility psychiatrist's did a good job of justifying polypharmacy. 46. The facility polypharmacy meeting was organized and thorough.		

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.		
Compliance rating:		
#	Indicator	Score
6	The individual is making expected progress	3/9 33%
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0/2 0%
8	The individual's progress note comments on the progress of the individual.	56% 5/9
9	If the individual was not making progress, worsening, and/or not stable,	0%

	corrective actions were identified/suggested.	0/2
10	Activity and/or revisions to treatment were implemented.	N/A
<p>Comments:</p> <p>6. Determinations of progress were limited because three individuals reviewed (Individual #77, Individual #112, Individual #34) did not have progress notes, and Individual #97's progress note was 12 months old and, therefore, not useful for determining progress. Three of the remaining five individuals were rated as making progress (Individual #98, Individual #65, Individual #36). It is critical that the facility ensure that all individuals with PBSPs have current progress notes to ensure the use of data based decisions.</p> <p>7. Progress notes indicated that two individuals (Individual #98, Individual #65) achieved some of their objectives, however no activity (e.g., development of new or revised objectives) was evident.</p> <p>8-9. All of the available progress notes commented on progress, however, none suggested actions to be taken to address a lack of progress (i.e., Individual #104, Individual #44).</p>		

Outcome 5 – Implementation/integrity of PBSP		
Compliance rating:		
#	Indicator	Score
17	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0/9 0%
18	There was a PBSP summary for float staff.	100% 9/9
19	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 9/9
<p>Comments:</p> <p>17. The data necessary to assess if direct support professionals implementing PBSPs were, in fact, trained on the plans were not available.</p> <p>18. Rio Grande State Center utilized a brief PBSP for DSPs.</p> <p>19. All of the functional assessments and PBSPs reviewed were written by a BCBA.</p>		

Outcome 6 – Reviews of PBSP		
Compliance rating:		
#	Indicator	Score
20	The graphs are useful for making data based treatment decisions.	0% 0/9
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	40% 2/5
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%
<p>Comments:</p> <p>20. One individual (Individual #34) did not have any graphs in his functional assessment or PBSP, and had no progress notes. The graphs of the remaining eight individuals were found to be difficult to interpret because behavioral data paths were combined with medication bar graphs in the same figure. It is</p>		

suggested that the figures be simplified, by separating graphs with medication from graphs of target behaviors, or graphing target behaviors and indicating medication changes with phase lines or with arrows.

21. The Monitoring Team observed five psychiatric clinic meetings. In Individual #77 and Individual #44's quarterly psychotropic medication reviews, current data were presented and graphed. These were the quarterly psychiatry clinics. Individual #65, Individual #34, and Individual #36's monthly psychiatric reviews, however, did not have timely data or graphs available to encourage data based decisions. These were considered to be interim, follow-up clinics, however, timely data should be available in these clinics, too.

22-23. Rio Grande State Center's two BCBA's and a BCBA consultant routinely met to review individuals' functional assessments and PBSPs. These meetings did not, however, contain minutes and often involved the review of PBSPs that were required for annual review/revision. Peer review should include the presentation and discussion of individuals for clinical reasons, not because an annual review is due. In other words, peer review should occur due to the lack of progress or because the behavioral health specialist requires some assistance from the peer review committee to improve clinical services. The facility should have peer review weekly and, once a month, include someone from outside of the facility (external peer review). Both internal and external peer review meetings should have meeting minutes that aid the facility in following up on recommendations from these peer review meetings.

Outcome 8 – Data collection

Compliance rating:

#	Indicator	Score
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	0% 0/9
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 9/9
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	0% 0/9
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	0% 0/9
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/9

Comments:

26. The data collection system for measuring target behaviors was judged to be inadequate because it was inflexible to individual needs (i.e., all individuals data collection involved recording the antecedents, behavior, and consequences for all target behaviors for all individuals with a PBSP), and the data recording was not timely (and, therefore, more likely to be inaccurate) because staff did not record data until the end of their 12 hour shift.

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

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

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

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

30. None of the individuals had IOA or data collection timeliness data. Seven of the individuals (all but Individual #77 and Individual #34) had treatment integrity data. Four of those individuals' PBSP data (Individual #65, Individual #112, Individual #44, Individual #97) achieved the facility's goal frequency for treatment integrity, however, none achieved the goal level. When unacceptable levels of reliability (i.e., IOA and DCT) or treatment integrity are identified, staff should be retrained and the reliability and/or integrity assessments re-administered.

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.

Compliance rating:

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

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #62 – constipation/bowel obstruction, and cardiac disease; Individual #145 – seizures, and constipation/bowel obstruction; Individual #92 – seizures, and dental; Individual #2 – cardiac disease, and gastrointestinal problems; Individual #112 – cardiac disease, and respiratory compromise; Individual #126 – aspiration, and seizures; Individual #19 – seizures, and osteoporosis; Individual #138 – osteoporosis, and other: metabolic syndrome; and Individual #65 – gastrointestinal problems, and other: polydipsia and borderline high serum sodium). For none of these risk areas did individuals have goals/objectives that were clinically relevant and achievable, and measurable.

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

Outcome 2 – Individuals receive timely and quality routine medical assessments and care.		
Compliance rating:		
#	Indicator	Score
g.	Individual receives timely preventative care:	
	i. Immunizations	89% 8/9
	ii. Colorectal cancer screening	25% 1/4
	iii. Breast cancer screening	50% 1/2
	iv. Vision screen	89% 8/9
	v. Hearing screen	89% 8/9
	vi. Osteoporosis	50% 4/8
	vii. Cervical cancer screening	75% 3/4
<p>Comments: g.i. through g.vii. A number of problems were noted with regard to preventative care for the nine individuals reviewed. More specifically, the following individuals did not have the following preventative care:</p> <ul style="list-style-type: none"> • Immunizations: Individual #138 (specifically, the varicella status was not documented); • Colorectal cancer screening: Individual #112, Individual #126, and Individual #19; • Breast cancer screening: Individual #19; • Vision screen: Individual #126; • Hearing screen: Individual #126; • Osteoporosis: Individual #62, Individual #145, Individual #138, and Individual #19; and • Cervical cancer screening: Individual #92. 		

Outcome 3 – Individuals with Do Not Resuscitate Orders (DNRs) have conditions justifying the orders.		
Compliance rating:		
#	Indicator	Score
a.	Individual with DNR has clinical condition that justifies the order and is consistent with the State Office Guidelines.	0% 0/3
<p>Comments: Of the individuals the Monitoring Team reviewed, Individual #62, Individual #19, and Individual #126, who died on 3/20/15, had DNR Orders, and/or documentation indicating that cardiopulmonary resuscitation (CPR) should not be initiated. Justification was not provided. For example:</p> <ul style="list-style-type: none"> • The only related documentation in Individual #126's record from the PCP was the following note entered on 2/20/15: The individual "spends his entire existence in a reclining chair but can be moved to a more upright position with help. He is non-verbal and has problems requiring frequent bronchoscopies for removal of phlegm and prevention of recurring pneumonias. It does not seem that in his semi-comatose state that traditional CPR is indicated." • Similarly, the following statement was entered into Individual #19's record on 2/24/15: "This is a case of intellectual and developmental disability in a woman who has physical and skeletal deformities that are fixed and would make conventional CPR extremely hazardous. She has severe osteoporosis, scoliosis and kyphoscoliosis and deformities that keep her in a compromised position. She spends all of her waking hours in a wheelchair. Therefore, in the event of cardiac arrest, we would not recommend any type of resuscitation." <p>The Facility did not submit any documentation on specifically what level of care would be withheld. In</p>		

some cases, it might be appropriate to not conduct CPR should a cardiac arrest occur. However, that does not necessarily mean that recommended dental care, preventive care etc. should not be provided.

Outcome 4 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Compliance rating:

#	Indicator	Score
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.	17% 1/6
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	0% 0/6
c.	If the individual requires hospitalization, an ED visit, or an Infirmiry admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <u>or</u> if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	40% 4/10
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmiry admission, the individual has a quality assessment documented in the IPN.	60% 3/5
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.	89% 8/9
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	100% 9/9
g.	Individual has a post-hospital ISPA that addresses supports to reduce risks and early recognition, as appropriate.	50% 4/8
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.	0% 0/9

Comments: a. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed six acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #145 (upper respiratory illness on 5/25/15, and facial trauma on 5/26/15), Individual #19 (vomiting/aspiration on 6/5/15), Individual #138 (vaginal discharge on 3/3/15), and Individual #2 (UTI on 6/1/15, and fever on 6/30/15). For these acute issues, medical providers at Rio Grande State Center followed accepted clinical practice in assessing the following: Individual #145 (upper respiratory illness on 5/25/15).

For a number of the remaining acute issues, PCPs did not conduct and document a focused physical examination, including documentation of all positive and negative findings; review and summarize the most recent diagnostic tests, including normal or negative results; and/or document a plan for further evaluation, treatment, and monitoring, including detail, as needed, regarding the monitoring the PCP and/or nursing staff are expected to complete.

Of significant note, for Individual #92, nursing staff documented that a table was dropped on her forearm. The physician was not notified, but nursing staff noted swelling and taped an ice pack to Individual #92's forearm. A note indicated: ""inform PNA to report to nursing when client hand turns black, signs or symptoms of pain." These indicators were not scored for this incident, because the physician did not know about it. However, this is an important example of the Facility's failure to provide appropriate care.

b. For none of these acute issues was documentation found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The following provide some examples of problems noted:

- With regard to Individual #145's upper respiratory illness on 5/25/15, the PCP saw him on 5/24/15, due to a fever. He was diagnosed with bronchitis and started on Zithromax. A chest x-ray (CXR), and labs were obtained, with the PCP noting that the individual would be re-evaluated the next day. The next medical documentation occurred on 5/26/15, at which time another PCP noted a markedly elevated white blood count with the assumption of a left shift. The CXR and urinalysis were noted to be pending. There was no further documentation of the individual's clinical status or results of the diagnostics.
- On 5/26/15, Individual #145's was involved in an altercation and PCP noted "a lot of soft tissue swelling in the left cheek." Observation and ice bags were ordered. There was no medical follow-up. Nursing documented that x-rays of the mandible were done and were negative. The PCP never documented the plan to obtain x-rays or the results. The only PCP documentation after 5/26/14 was a note addressing the inaccuracy of the hepatitis status as documented in the 2014 AMA.
- On 6/5/15, the PCP saw Individual #19 due to two episodes of emesis over past week. It was not clear when nursing staff notified the PCP. A CXR and complete blood count were done due to likely diagnosis of aspiration pneumonia. The PCP noted bilateral wheezing along with rales. The IPN documentation was brief and did not include pertinent positive and negative findings. This individual was being treated with Levaquin and was considered ill enough to have intramuscular Rocephin ordered for four days. On 6/8/15, another PCP saw the individual and documented a very thorough assessment. The CXR showed pulmonary congestion so furosemide was prescribed. Diagnostics including an electrocardiogram (EKG), and b-type natriuretic peptide (BNP) blood test were ordered. The covering PCP indicated the primary PCP would see the individual the next day, but there was no documentation that this occurred. There was no documentation of the follow-up, inclusive of clinical status and findings from the studies performed.
- For Individual #138, the IPN provided documentation of vaginal irritation, redness, and discomfort over a period of several months. On 3/3/15, the PCP noted splotches of red skin in an individual with excessive weight. Nursing documented a white vaginal discharge. A referral was made to the dietician. On 4/29/15, the PCP superficially visualized a rash in the groin area and prescribed Mycostatin. Documentation continued to show that the problem was not resolved. No referral was made to GYN for further assessment.

- For Individual #2, there was a five-day delay in medical assessment. On 5/28/15, nursing documented that the individual was unable to urinate completely. It was documented that she would see the PCP. On 6/1/15, the individual reported nausea and was noted to be sneezing. A temperature of 100.9 was documented. On 6/2/15, labs and a urinalysis were completed. The results were reported to the PCP at 7:30 p.m. There were no new orders. On 6/3/15, there was documentation of a medical assessment. The PCP noted that the individual was in the clinic with a slight temperature. The head, eyes, ears, and throat were documented as "unremarkable." On 6/4/15, the PCP documented a positive urine culture and Amoxicillin was started. There was no follow-up for this event. The next and final PCP IPN entry was dated 6/30/15.

c. Ten acute illnesses requiring hospital admission, or ED visit were reviewed including the following with dates of occurrence: Individual #62 (1/10/15 – small bowel obstruction, and 3/22/15 - sepsis), Individual #145 (2/19/15 – neuroleptic malignant syndrome), Individual #19 (4/12/15 – aspiration pneumonia, and 3/4/15 - seizures), Individual #112 (2/18/15 – pneumonia, and 5/13/15 - tachycardia), Individual #65 (4/8/15 - pneumonia), Individual #138 (outpatient dental surgery), and Individual #126 (2/24/15 – aspiration pneumonia). For the following, PCP IPNs summarizing the events leading up to the acute event and the disposition were available and completed timely: Individual #62 (3/22/15 - sepsis), Individual #145 (2/19/15 – neuroleptic malignant syndrome), Individual #19 (4/12/15 – aspiration pneumonia), and Individual #112 (5/13/15 - tachycardia).

d. Five of the acute illnesses reviewed occurred after hours or otherwise did not require a medical assessment, including: Individual #62 (1/10/15 – small bowel obstruction, and 3/22/15 - sepsis), Individual #112 (2/18/15 – pneumonia), Individual #65 (4/8/15 - pneumonia), and Individual #138 (outpatient dental surgery). For the remaining acute illnesses, the following individuals had a quality assessment documented in the IPN: Individual #145 (2/19/15 – neuroleptic malignant syndrome), Individual #19 (4/12/15 – aspiration pneumonia), and Individual #112 (5/13/15 - tachycardia).

e. Indicators e, f, and g were not applicable for Individual #138 (outpatient dental surgery). For the remaining acute illnesses reviewed, the individual that did not receive timely treatment at the State Center was: Individual #126 (2/24/15 – aspiration pneumonia). On 2/24/15, nursing staff documented that the individual had 10 seconds of stiffness in his arms and legs, and then vomited at 11:30 a.m. The lungs were noted to have expiratory wheezing. Enteral feeding was stopped. Around 1 p.m., the PCP was notified and per nursing, conducted an assessment. The individual was transferred to the ED around 3 p.m. and returned to the Facility around 10:48 p.m., with a diagnosis of dyspnea. He was noted to be sleepy and have rhonchi. On 2/25/15, nursing documented discharge from the eyes and that the individual was being placed on sick call. On 2/26/15, the individual had an outpatient bronchoscopy, where the pulmonologist documented copious amounts of thick secretions were suctioned. He was admitted to the hospital for bilateral pneumonia and died on 3/20/15. There was no documentation by the PCP related to any of these events.

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

g. IDTs met and developed post-hospital ISPA's to address prevention and early recognition of signs and symptoms of illness for the following acute illnesses: Individual #62 (3/22/15 - sepsis), Individual #145 (2/19/15 – neuroleptic malignant syndrome), Individual #112 (5/13/15 - tachycardia), and Individual #65 (4/8/15 - pneumonia).

h. PCPs did not conduct follow-up assessments and documentation initially upon return to the Facility, as well as in accordance with the individuals' status and presenting problem through to resolution of the acute illness for any of the acute illnesses reviewed. Some of the problems noted included:

- On 1/12/15, Individual #62 returned to the Facility, and on 1/13/15, the PCP saw him. No additional follow-up was documented for this individual with a diagnosis of small bowel obstruction. The IDT did not hold the ISPA meeting until 1/23/15.
- Individual #145 was sent to the ED for fever and leukocytosis. He returned to the Facility without

assessment due to behavior. He was given Ativan and Benadryl intramuscular (IM) upon return. He was sent to ED again due to a temperature of 103.4, where he was diagnosed with neuroleptic malignant syndrome and pneumonia. He also had bradycardia. On 2/24/15, he returned to the Facility. On 2/26/15, a physician assessed him. The next medical documentation was on 4/1/15. This was an assessment of the occurrence of an ADR to Clozaril.

- On 4/12/15, the on-call PCP evaluated Individual #19 for wheezing. The documentation of the medical evaluation was quite thorough. Aspiration was suspected, and the individual was sent to the ED for evaluation. On 4/13/15, the individual returned from the ED with a diagnosis of bronchitis, and the covering PCP evaluated her, providing good documentation of the assessment and noted "we will follow closely at this point." However, there was no documentation of follow-up.
- On 4/6/15, nursing documented that Individual #65 had emesis. On 4/7/15, the PCP noted that the individual was a big water drinker who would drink three to four bottles of water then throw-up. Antacids were prescribed. On 4/8/15, nursing documented that the individual was wheezing and shaking in bed around 12:45 a.m. At 1:25 a.m., the individual was transported to the ED and was admitted with pneumonia. On 4/9/15 in the late evening, he returned from the hospital with the diagnosis of pneumonia. On 4/10/15, the PCP saw him for post-hospital assessment. There was no additional follow-up related to this pneumonia hospitalization. The next PCP note was dated 5/11/15, and it addressed vomiting.
- Per nursing documentation, on 5/29/15, Individual #138 had full dental rehabilitation at the hospital under anesthesia. The individual returned to the Facility at 4:30 p.m., and was noted to be drowsy, cooperative and have itching to the chest area. At 5:30 p.m., Phenergan IM was administered. At 9:29 p.m., a nursing IPN entry documented that no pre-anesthesia vital signs were recorded. The individual had an unsteady gait, looked somewhat pale, was nauseated, and throwing up. On 5/30/15 at 4:58 a.m., nursing documented that the PCP gave orders at 1:40 a.m. for pain medication because the individual was crying and complaining of pain to the face. The nurse documented that there was an attempt to provide the PCP with a status update at 10:12 a.m., but there was no answer. There was no other documentation related to this individual having a dental procedure under general anesthesia. The PCP did not document any medical assessment prior to surgery or following surgery. There was no documentation in the dental notes of a procedure on this date.

Outcome 5 – Individuals’ care and treatment is informed through non-Facility consultations.		
Compliance rating:		
#	Indicator	Score
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	100% 15/15
b.	PCP completes review within five business days, or sooner if clinically indicated.	93% 14/15
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	0% 0/15
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	79% 11/14
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/13
Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #62 for surgery on 2/23/15, and ophthalmology on 6/12/15; Individual #145 for cardiology on 4/14/15, and ear, nose and throat on 3/23/15; Individual #92 for gynecology on 4/8/15; Individual #2 for cardiology on 2/2/15, and gynecology on 1/21/15; Individual #112 for cardiology on 1/20/15, and pulmonary on 6/17/15; Individual #19 for neurology on 5/20/15, and gastroenterology; Individual #138 for ophthalmology on 5/4/15, and ear, nose, and throat on		

6/11/15; and Individual #65 for gastroenterology on 6/22/15, and dermatology on 6/30/15.

a. through c. It was positive that for the individuals reviewed, PCPs reviewed and initialed consultation reports, indicated agreement or disagreement with the recommendations. However, they did not write corresponding IPNs, which resulted in a lack of a summary regarding the significance of the consult and documentation of the need for IDT referral. The consultation that was not reviewed timely was Individual #62 for surgery on 2/23/15.

d. This indicator was not applicable for Individual #138 for ear, nose, and throat. It was good to see that corresponding orders were found for many of the remaining consultations reviewed. The exceptions were: Individual #62 for surgery on 2/23/15; and Individual #145 for cardiology on 4/14/15, and ear, nose and throat on 3/23/15.

e. This indicator was not applicable for Individual #2 for cardiology on 2/2/15, and gynecology on 1/21/15. It was concerning that for the remaining consultations reviewed, individuals' IDTs did not meet to discuss the results.

Outcome 6 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.

Compliance rating:

#	Indicator	Score
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.	44% 8/18

Comments: For nine individuals, two of their chronic diagnoses and/or at-risk conditions were selected for review (i.e., Individual #62 – constipation/bowel obstruction, and cardiac disease; Individual #145 – seizures, and constipation/bowel obstruction; Individual #92 – seizures, and dental; Individual #2 – cardiac disease, and gastrointestinal problems; Individual #112 – cardiac disease, and respiratory compromise; Individual #126 – aspiration, and seizures; Individual #19 – seizures, and osteoporosis; Individual #138 – osteoporosis, and other: metabolic syndrome; and Individual #65 – gastrointestinal problems, and other: polydipsia and borderline high serum sodium).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #62 – constipation/bowel obstruction, and cardiac disease; Individual #145 – seizures, and constipation/bowel obstruction; Individual #2 – cardiac disease; Individual #112 – cardiac disease, and respiratory compromise; and Individual #19 – seizures. The following provide examples of thorough medical assessments, tests, and evaluations:

- Individual #112 had a history of atrial fibrillation/atrial flutter that required direct current cardioversion shortly after admission to the Facility. He subsequently underwent a cardiac ablation, and was also treated with Amiodarone. The individual had close follow-up by cardiology. The individual also had a history of congestive heart failure, with the cardiologist noting that the cardiomyopathy was related to tachycardia.
- Neurology followed Individual #19, and in May 2015, she began seeing a new neurologist. However, the PCP documented very little about the management of the seizure disorder. Most of the information/documentation related to seizure management was found in documents such as the QDRRs and consult notes.

The following provide some examples of problems noted:

- Individual #2 had non-alcoholic liver disease. The AMA provided no information on the etiology. The IRRF stated that the diagnosis was fatty liver and gastroenterology had evaluated the individual and liver enzymes reportedly had normalized. The AMA did not document the liver enzymes.

- For Individual #138, the PCP agreed with a recommendation for a DEXA scan for this individual who was treated with medications that increased her risk for osteoporosis. However, a DEXA scan had not been completed. This individual also had multiple risks for metabolic syndrome/diabetes mellitus. The 2014 AMA listed an active diagnosis of hypertension, obesity, and hypothyroidism. Obesity was addressed with only a referral to the dietician. The individual had a documented low high-density lipoprotein (HDL) and elevated glucose of 126 that were not addressed in the IPNs, quarterly medical summaries, etc.
- For Individual #65, who was at risk related to gastrointestinal problems, and other: polydipsia and borderline high serum sodium, did not have a current AMA and no quarterly medical summary was submitted for 2015. There was little medical evaluation of the polydipsia, which likely played a role in the recurrent emesis. The polydipsia appeared to be primarily considered a behavioral issue. Lab values indicated normal and borderline high serum sodium levels. These are characteristic findings in individuals with diabetes insipidus who have access to water and constantly drink. The IPN documentation stated that: "he is a big water drinker. He will drink 3 or 4 bottles of water and then throw up. This may be a behavioral problem but we are not sure." The individual had documented behavioral issues and multiple GI problems, including reflux esophagitis and hiatal hernia. However, the records did not document an appropriate medical evaluation for an individual with polydipsia and borderline high serum sodium with no evidence of low volume status (based on labs and vital signs, and clinical documentation). The appropriate diagnostic work-up is necessary to determine if there is a medical etiology for the polydipsia.

During the week after the onsite review, the Monitoring Teams shared concerns about Individual #65 with the State, including the need for further medical evaluation related to these issues. In its response, the State indicated: "...[the PCP's] first approach to solve the issue of emesis is to find out what is being described by the staff as 'vomiting.' Whether it is forcible expulsion of stomach contents which is vomiting, or, having what would be better described as regurgitation. [The PCP] will follow-up with staff interviews to determine... [The PCP] has ordered some basic lab studies – monitoring intake of fluids, 24 hour urine collection, total urinary volume, both plasma and urine osmolality, plasma anti-diuretic hormone level, and repeat SMA-7... Currently [Individual #65] is not demonstrating any evidence of volume overload and is free of edema. Examination of abdomen is benign, with no evidence of masses. Laboratory data shows no concerns with hepatobiliary process. Etiology of vomiting episodes is not believed to be related to being hepatic, pancreatic, or biliary in nature, nor polydipsia or diabetes insipidus of any kind (individual does not have diabetes)... Upon review of the intake history beginning 8/6/15, the psychiatrist states the amount of fluid is not excessive for this individual, especially during the hot summer months... The IDT discussed the findings of the sodium levels and determined that this is not a concern as they range from 142-144, which is upper level normal. It has never reached 150 (high abnormal) or above. [Individual #65's] PCP and psychiatrist do not feel the sodium levels are of concern at this time... All labs were reviewed and are normal. Weight has remained stable... Four GI consults from 1/22/15 to present were reviewed by the IDT. Two were EGDs obtained, with recommendations for omeprazole to be started, as well as anti-reflux measures. Both of these measures were implemented and found to be ineffective. An abdominal sonogram, a HIDA scan and an ultrasound were all completed. All findings were normal. Medication adjustments were made as needed and determined to be ineffective at today's meeting."

The Monitoring Teams appreciate that the IDT reviewed the concerns and have taken some actions to address them. However, it is incorrect to report that Individual #65's serum sodium levels are normal. He had documented hypernatremia since October 2014, with values ranging from 142 to 145. The Facility's lab listed normal values as 134 to 142. The last three values were 145, noting an upward trend. Again, Individual #65's records consistently documented excessive water drinking with the PCP noting: "he is a big water drinker. He will drink 3 or 4 bottles of water and then throw up. This may be a behavioral problem but we are not sure." There is a very specific approach to evaluating hypernatremia and the differential for hypernatremia can be lengthy. However, a high-normal sodium is characteristic in individuals with diabetes insipidus who have access to water and constantly drink. An appropriate evaluation is necessary to determine the

etiology. The psychiatrist also reported that this individual had a history of lithium use, which places him at risk for diabetes insipidus. Individual #65 might benefit from a referral to the appropriate consultant, either nephrology (preferable) or endocrinology.

Outcome 8 – Individuals’ ISP plans addressing their at-risk conditions are implemented timely and completely.

Compliance rating:

#	Indicator	Score
a.	The individual’s medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	17% 3/18

Comments: a. For the individuals’ chronic conditions/at-risk diagnoses reviewed, evidence was found of thorough implementation of the medical interventions, including specific data to show their efficacy, for the following five conditions: Individual #62 –cardiac disease, Individual #145 – seizures, and Individual #2 – cardiac disease.

As illustrated above with regard to Domain #2, ISPs/IHCPs infrequently set forth specific plans with detailed interventions and strategies. As a result, it was difficult to determine whether or not such plans were implemented thoroughly, and often, summary data was not available to determine whether or not plans were implemented and/or the efficacy of the plans. Some of the specific issues with regard to the implementation of medical care included:

- On 6/24/15, Individual #145 had a gastroenterology consult due to diagnosis of iron deficiency anemia. Gastroenterology recommended a colonoscopy due to possible colon arteriovenous malformations, polyps, ulcer, or cancer. There was no IPN documentation of this or referral to the IDT for preparation. A review of physician orders indicated that a bowel prep was ordered for colonoscopy on 7/24/15.
- The PCP had no IPN entries for Individual #92. As such, there was no assessment of dental status from the medical perspective, and no medical review documented before this individual had general anesthesia.
- Individual #112 was started on metoprolol for control of hypertension. This drug would also be beneficial for management of his arrhythmia and heart failure. However, it was inadvertently discontinued. Per the PCP on 6/23/15, "he ran out on 6/20/15 and it was not renewed."
- Individual #126, who died on 3/20/15, had significant problems with management of secretions. It had also been noted that suctioning did not always occur as required. The PCP noted his problems required frequent bronchoscopy for removal of phlegm and prevention of recurring pneumonia. The PCP never documented specific management of secretions, and there was no discussion of alternative strategies/treatments to manage what was documented as copious amounts of secretions.
- In addition, according to the 2014 IRRF for Individual #126, who died on 3/20/15, "staff believed he may have had a seizure but it was determined to be a behavior by the tenured PCP." Per the 2/23/15 QDRR, the Clinical Pharmacist noted "no formal seizure diagnosis. Pt [patient] has 3 reported seizures in November 2014. EEG 4/14/14 showed normal activity. Consider neurological follow-up." The IPNs included several entries by nursing describing episodes of stiffening of arms and legs. There was no documentation of a medical assessment related to this.
- Individual #19 was rated at high risk for osteoporosis. She had a diagnosis of osteoporosis and was treated with multiple antiepileptic drugs that increase risk. Per the IRRF, the last bone mass density test was in 2012, and the PCP was to be alerted to the need for a repeat study because this individual received Prolia. The date of the most recent bone mass density report submitted was 1/6/11. The QDRR noted the last bone mass density was 2012. The PCP disagreed with the need to obtain a bone mass density test stating the individual was not a candidate for bisphosphonates. However the individual was treated with Prolia, and had not had a follow-up test in three to four years to determine if therapy was effective. The dental IPNs included a note, dated 5/13/15, documenting that this individual had a neurological consultation in 2013, in which there was discussion of a C3-C4 subluxation. This information was not discussed in the AMA or included as a

diagnosis in the active problem list. This is a very important diagnosis in the management of this individual. The subluxation had precluded the placement of a vagus nerve stimulator per the note. It also complicates any treatments that require anesthesia and intubation due to the risk of a devastating spinal cord injury. It was noted that during the dental discussion (IRRF), IDT members surfaced concerns about this related to other procedures. All medical providers should be made aware of this diagnosis.

Pharmacy

Outcome 1 – As a result of the pharmacy’s review of new medication orders, the impact on individuals of significant interactions with the individual’s current medication regimen, side effects, and allergies are minimized; any necessary additional laboratory testing is completed regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.

Compliance rating:

#	Indicator	Score
a.	If the individual has new medications, the pharmacy completed a new order review prior to dispensing the medication; and	100% 17/17
b.	If an intervention was necessary, the pharmacy notified the prescribing practitioner.	100% 1/1

Comments: a. For nine of the nine individuals reviewed, a total of 17 newly prescribed medications were identified. For each new medication order, the pharmacy completed a checklist that was seen on the Physician Order forms. Items covered included allergies, dose, indication, interactions, stop dates, lab, and diagnosis review. The Pharmacist initialed and dated each checklist label, which was seen on the pharmacy (annotated) copy of the physician orders.

b. The one for which documentation of an intervention was submitted was Prevacid for Individual #65. Of note, several WORx document requests were noted to be "NA." It is not clear what the Facility meant by this notation. Some documents labeled "NA" had a second sheet that noted "not available." The Pharmacy Director reported that entries into WORx were inconsistent due to staffing shortage, but the communication with the prescribing physicians occurred.

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.

Compliance rating:

#	Indicator	Score
a.	QDRRs are completed quarterly by the pharmacist.	94% 17/18
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;	100% 17/17
	ii. Benzodiazepine use;	100% 17/17
	iii. Medication polypharmacy;	100% 17/17
	iv. New generation antipsychotic use; and	100% 8/8
	v. Anticholinergic burden.	100%

		17/17
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 17/17
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 14/14
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs and patient interventions.	88% 15/17
<p>Comments: a. The Monitoring Team requested the last two QDRRs for nine individuals (i.e., Individual #62, Individual #145, Individual #92, Individual #2, Individual #112, Individual #126, Individual #19, Individual #138, and Individual #65). It was positive that generally the individuals reviewed had current QDRRs. The exception was one QDRR for Individual #126, which was 18 months old (i.e., completed 12/30/13). However, it is important to note, that most individuals did not have timely QDRRs prior to 2015. In several cases, prior to early 2015, the previous QDRR was completed in 2013 or early 2014 (e.g., Individual #62 with a completion date of 3/14/13, Individual #145 with a completion date of 7/24/13, Individual #19 with a completion date of 4/30/13, Individual #92 with a completion date of 1/18/14, and Individual #138 with a completion date of 5/14/14). Although it was positive that the Facility had caught up on the completion of QDRRs, this lapse in their completion was concerning.</p> <p>b. It was positive that the QDRRs reviewed included thorough reviews and recommendations related to lab results, benzodiazepine use, medication polypharmacy, new generation anti-psychotic use, and anticholinergic burden. Overall, the Clinical Pharmacist/Pharmacy Director did a nice job with the QDRRs. He covered all of the required elements and provided good information on the use of benzodiazepines and anticholinergic burden. The recommendations were relevant to the care of the individuals, and for the most part, were clinically sound.</p> <p>c. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a rationale for lack of agreement with Pharmacy's recommendations. It should be noted that although rationales were provided, they did not always seem to provide sufficient justification for not agreeing with the recommendations and/or implementing alternatives. For example:</p> <ul style="list-style-type: none"> • For Individual #19, QDRR dated 4/3/15, the PCP disagreed with all five recommendations, but it was unclear why the PCP believed a colonoscopy was not indicated. Moreover, the PCP did not accept the recommendation to obtain a DEXA stating that the individual was not a candidate for bisphosphonates. However, the records indicated the individual was prescribed Prolia, and this was an indication for monitoring bone mineral density. • For Individual #145, the Clinical Pharmacist recommended obtaining a DEXA scan due to antiepileptic drug (AED) use. This seemed reasonable, because the use of Dilantin and other AEDs increases the risk for the development of osteoporosis. However, the PCP disagreed with no explanation. • For Individual #112, QDRR dated 7/6/15, the Clinical Pharmacist recommended that a chest x-ray be obtained to monitor for development of pulmonary fibrosis due to Amiodarone use. The PCP declined the recommendation stating a routine chest x-ray was not indicated. However, the PCP did not indicate how the individual would be monitored for development of Amiodarone-associated pulmonary fibrosis. • For Individual #112, QDRR dated 4/20/15, the Clinical Pharmacist recommended that monthly blood glucose levels be obtained due to elevated Hemoglobin (Hb) A1c. The PCP disagreed even though the HbA1c of 5.9 is considered in the pre-diabetes range. <p>d. This was not applicable for the following QDRRs: Individual #62, dated 1/3/15; Individual #2, dated 6/29/15; Individual #126, dated 2/23/15; and Individual #19, dated 4/3/15. Patient interventions for which this was applicable were those for Individual #65 (1), Individual #112 (1), Individual #19 (2), and</p>		

Individual #145 (1). The agreed-upon recommendations for which timely implementation did not occur were:

- For Individual #138, a recommendation in the 3/18/15 QDRR for a DEXA scan was not implemented.
- For Individual #65, the prescribing physician agreed to a recommendation in the 4/14/15 QDRR to obtain a lipid panel, because the individual received medical therapy and new generation antipsychotics and had not had a lipid panel done since July 2014. The recommendation was not implemented until July 2015.

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/9
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9
<p>Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings (i.e., Individual #62, Individual #145, Individual #92, Individual #2, Individual #112, Individual #126, Individual #19, Individual #138, and Individual #65). None of the goals/objectives for the nine individuals were clinically relevant and achievable, or measurable and time-bound.</p> <p>c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these individuals.</p>		

Outcome 4 – Individuals maintain optimal oral hygiene.		
Compliance rating:		
#	Indicator	Score
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.	88% 7/8
b.	At each preventive visit, the individual and/or his/her staff have received tooth-brushing instruction from Dental Department staff.	0% 0/9
c.	Individual has had x-rays, unless a justification has been provided for not conducting x-rays.	78% 7/9
d.	If the individual has need for restorative work, it is completed in a timely manner.	33% 2/6
e.	If the individual requires an extraction, it is done only when restorative options are exhausted.	0% 0/1
Comments: a. Individual #126 was edentulous. The individual reviewed who did not receive prophylactic		

dental care at least twice a year was Individual #62.

b. It was concerning that for the individuals reviewed, there was no evidence that dental staff provided tooth-brushing instruction during preventative visits. The exception to this was those individuals who attended dental rehearsals.

c. The individuals the Monitoring Team reviewed who did not receive needed dental x-rays or information was not available were Individual #62, and Individual #19.

d. Individual #92 and Individual #112 had timely restorative work completed. Those individuals who did not were:

- Individual #62, for whom a 6/22/15 exam documented moderate dental caries for which no clear plan was documented;
- Individual #19, for whom “rampant decay” was not addressed;
- Individual #138, for whom moderate decay was identified on 10/6/14. On 1/14/15, rampant decay was noted. The nursing IPNs documented that full-mouth dental rehabilitation occurred on 5/26/15. However, there was no dental documentation related to this; and
- Individual #65, for whom “rampant decay” and the need for extraction of 14 root tips (i.e., full mouth extraction) in a hospital setting had been identified six months prior to the Monitoring Team’s onsite review.

e. Individual #92 had extractions, but informed consent was not available for review.

Outcome 6 – Individuals receive timely, complete emergency dental care.

Compliance rating:

#	Indicator	Score
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. None of the individuals reviewed had dental emergencies.

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

Compliance rating:

#	Indicator	Score
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 2/2
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/2
d.	At least monthly, the individual’s ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2

Comments: a. None of the individuals had been assessed as needing suction tooth brushing. This was concerning, because:

- Individual #112 had a percutaneous endoscopic gastrostomy tube (PEG tube), which usually indicates the need for suction tooth brushing;
- According to the dental examination, Individual #126 did not need suction tooth brushing, but his IRRF indicated he did require it after meals. However, in Document Request #70, the Facility

<p>indicated he did not need suction tooth brushing.</p> <ul style="list-style-type: none"> According to the dental examination, Individual #19 did not need suction tooth brushing. However, based on review of the Medication Administration Record, she received it. However, the Monitoring Team could not determine if the appropriate drug holiday was implemented (i.e., chlorhexidine should not be used continuously). <p>b. through d. Documentation was present to show that Individual #126 and Individual #19 received suction tooth brushing. However, documentation was not submitted to show monitoring and/or review of specific data.</p>
--

Outcome 8 – Individuals who need them have dentures.		
Compliance rating:		
#	Indicator	Score
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	11% 1/9
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A
Comments: a. and b. No or insufficient information was found for eight individuals. For Individual #65, the annual dental exam section regarding dentures was blank. However, the RDH noted in the IPN that the individual would be assessed for upper and lower dentures after full mouth extraction.		

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.		
Compliance rating:		
#	Indicator	Score
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	17% 2/12
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.	8% 1/12
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	8% 1/12
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	33% 1/3
e.	The individual has an acute care plan that meets his/her needs.	0% 0/12
f.	The individual’s acute care plan is implemented.	0% 0/12
Comments: The Monitoring Team reviewed 12 acute illnesses and/or acute occurrences for seven individuals, including Individual #112 – low-grade UTI, and pneumonia; Individual #65 – pneumonia, neuro-dermatitis, and frequent vomiting; Individual #19 – yeast at PEG-tube site, conjunctivitis, and dermatitis/incontinence; Individual #2 – UTI; Individual #138 – pattern of injuries of unknown origin; Individual #145 – Helicobacter pylori (H. pylori); and Individual #62 – sepsis.		
<p>a. The acute illnesses/occurrences for which nursing assessments were completed in alignment with the individuals’ needs and nursing protocols or current standards of care were those for Individual #65 – pneumonia, and Individual #19 – dermatitis/incontinence. The following provide some examples of concerns noted:</p> <ul style="list-style-type: none"> With regard to Individual #112’s low-grade UTI, there was a lack of nursing assessment and 		

follow-up. On 1/30/15, an IPN noted he had an elevated temperature, but no specific IPN addressed this or documented an assessment.

- With regard to Individual #112's pneumonia, although there were large gaps in the documentation, the IPNs indicated he had been having changes in status for weeks without nursing staff recognizing it. For example, he was coughing, and had large variations in vital signs. On 2/16/15, an IPN indicated he was "coughing and then he vomited." On 2/18/15, an IPN indicated he was "coughing and shaking."
- The IPNs indicated that Individual #65 had frequent episodes of vomiting, but no acute care plan addressed this issue. Nursing assessments were not consistently conducted when vomiting episodes occurred. The IHCP did not address interventions for vomiting episodes.
- No nursing assessment was found for Individual #19's eye infection (i.e., conjunctivitis).
- With regard to Individual #145's H. pylori, it is unclear how it was diagnosed. However, he lost 10.5 percent of his weight. Nursing IPNs did not document the weight loss or any related assessments when the weight loss was discovered.
- Individual #62 was hospitalized for sepsis, which is a major systemic infection. No nursing IPNs were submitted for the period between 3/20/15, and a note on 3/23/15, which noted he was hospitalized for sepsis. No IPNs or other CWS documentation that the Facility provided addressed when or why the PCP was notified of a change of status or when or why Individual #62 was sent to the hospital.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms was: Individual #19 –dermatitis/incontinence. For the remaining events, in some instances, the PCP was not notified. In other instances, the PCP was notified, but the information documented as having been communicated to the PCP was not sufficient given the individual's current health status and risk.

c. The illness/occurrence for which nurses conducted ongoing nursing assessments consistent with the individual's medical status and in alignment with nursing protocols was for Individual #145's H. pylori. Once the H. pylori was diagnosed, nursing assessments were consistent and met the individual's needs. In fact, the documented nursing assessments were better than the assessments that the related acute care plan required.

d. This indicator was applicable for Individual #112 –pneumonia, Individual #65 – pneumonia, and Individual #62 – sepsis. The individual that had the necessary nursing assessments was Individual #112 – pneumonia.

e. In some cases, an acute care plan should have been developed, but was not. For those that were developed, problems included, for example, plans not providing instructions regarding follow-up nursing assessments; not being in alignment with nursing protocols; not including specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; not defining the clinical indicators nursing would measure; and not identifying the frequency with which monitoring should occur.

f. As noted above, acute care plans did not include all of the necessary components. Even for the interventions that were included, documentation was not present to show that the plans were implemented as often as indicated by the individual's health status, that nurses conducted ongoing monitoring of the individuals' acute illnesses/injuries, or that nursing staff followed the acute illnesses/injuries through to resolution.

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal/objective that is clinically relevant and achievable to	0%

	measure the efficacy of interventions.	0/18
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	0% 0/18
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18
d.	Individual has made progress on his/her goal/objective.	0% 0/18
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18
<p>Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #112 – aspiration, and cardiac disease; Individual #65 – gastrointestinal problems, and fluid imbalance; Individual #92 – dental, and weight; Individual #19 – UTIs, pain, and skin integrity; Individual #2 - dental, and polypharmacy/side effects; Individual #138 – constipation/bowel obstruction, and skin integrity; Individual #145 – respiratory compromise, and behavioral health; Individual #62 – skin integrity, and weight; and Individual #126 – other: all risk factors). None of the IHCPs included clinically relevant, achievable, and measurable goals/objectives.</p> <p>c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of nursing supports and services to these nine individuals.</p>		

Outcome 5 – Individuals’ ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.		
Compliance rating:		
#	Indicator	Score
a.	The nursing interventions in the individual’s ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/17
c.	The individual’s nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18
<p>Comments: As noted above, the Monitoring Team reviewed a total of 18 IHCPs for nine individuals addressing specific risk areas.</p> <p>a. For the individuals reviewed, evidence was not provided to support that individuals’ IHCPs were implemented beginning within 14 days of finalization or sooner. For individuals with medium and high mental health and physical health risks, IHCPs generally did not meet their needs due to the lack of inclusion of regular assessments in alignment with nursing protocols. As a result, data was not available to show implementation of such assessments.</p> <p>b. This indicator was not applicable to Individual #92’s weight. Some examples of concerns noted included:</p> <ul style="list-style-type: none"> For Individual #126, who died on 3/20/15, an ISPA noted that e coli was found in his lungs, and that it was yet to be determined how the e coli got into his lungs. No plan was implemented to monitor/observe his care to assist in determining the etiology and/or implement action steps to prevent it from happening again. The Q Facilitator asked the PCP how e coli could get into his lungs, and the IRRF noted the PCP stated: "e coli in the lungs is part of [Individual #126’s] aspiration risk." It was unclear what this meant. The IRRF also noted that he had two episodes of 		

<p>vomiting, because he was overfed (i.e., he had a G-tube), which might have been a result of a malfunctioning feeding pump. Although the IRRF noted the pump was checked and was working properly, the floor nurses were retrained regarding the process of how to program the pumps. The IRRF noted that the PNMP nurse stated that she "discovered the process was not being followed."</p> <ul style="list-style-type: none"> • For Individual #65, the vomiting episodes he was/is experiencing, which had taken a negative toll on his overall health and dental health, were never analyzed to identify any trends. In addition, the IDT indicated that his fluids should be restricted, but did not take any actions to assist Individual with measuring and limiting his own fluid intake. Concerns related to his medical evaluation and treatment are discussed elsewhere in this report. • A dental note indicated that Individual #92 had many dental issues, but no new nursing interventions were implemented. • For Individual #19, actions were not identified and/or taken after each UTI to prevent them. In addition, Facility staff indicated that no bowel tracking sheets were available, which was problematic given her risk of constipation as well as her UTIs caused by e coli. • For Individual #145, even after an episode of pneumonia, nursing staff did not implement regular respiratory assessments, and the IDT did not add them to the IHCP.
--

Outcome 6 – Individuals receive medications prescribed in a safe manner.		
Compliance rating:		
#	Indicator	Score
a.	Individual receives prescribed medications.	93% 14/15
b.	Medications that are not administered or the individual does not accept are explained.	0% 0/4
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7
d.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual’s response.	25% 1/4
e.	Individual’s PNMP plan is followed during medication administration.	71% 5/7
f.	Infection Control Practices are followed before, during, and after the administration of the individual’s medications.	100% 7/7
g.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/7
h.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/7
i.	If an ADR occurs, the individual’s reactions are reported in the IPNs.	0% 0/1
j.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/1
k.	If the individual is subject to a medication variance, there is proper reporting of the variance.	75% 6/8
l.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	50% 2/4
Comments: The Monitoring Team conducted record reviews for eight individuals and observations of medication administration for seven individuals, including: Individual #62, Individual #145, Individual		

#92, Individual #2 (no observation completed), Individual #112, Individual #19, Individual #138, and Individual #65.

a. Based on record reviews as well as the onsite observations, individuals generally received their prescribed medications, with the exception of Individual #19, for whom Medication Administration Record (MAR) blanks were found.

b. The individuals for whom medications were not administered, and for which there were no explanations were Individual #112, Individual #65, Individual #19, and Individual #145.

c. It was positive that the nine rights were followed for all of the individuals the Monitoring Team member observed during medication passes.

d. The individuals for whom reactions to PRN medications were not consistently documented were Individual #112, Individual #19, and Individual #145. Necessary documentation was present for Individual #2.

e. During the Monitoring Team's observations, nursing staff did not follow the PNMPs for Individual #65, and Individual #92. Both of these individuals eat independently, but nurses fed them their medications.

f. It was positive that during the Monitoring Team's observations, nursing staff observed infection control practices.

g. This indicator was not applicable to Individual #92. For the remaining records reviewed, evidence was not present to show that instructions were provided to the individuals and their staff regarding new orders or when orders changed.

h. This indicator was not applicable to Individual #92. For the remaining individuals, when a new medication was initiated, when there was a change in dosage, and/or after discontinuing a medication, documentation was not present to show they were monitored for possible adverse drug reactions.

i. and j. Individual #145 had an ADR related to Clozaril. On 2/17/15, the Licensed Vocational Nurse (LVN) noted Individual #145 was staggering and walking slowly. The note indicated that the LVN notified the RN Case Manager, who assessed the individual. However, the RN Case Manager did not document an assessment in the IPNs. No other assessments were found until 2/19/15, when the IPN indicated that he was being sent to the ED due to a suspected drug reaction. This IPN did not document a nursing assessment, and there was no indication when the PCP was notified to give the order to send the individual to the ED. Three hours later, an IPN noted that the nurse called the ED to give report and noted that Ativan 2 milligrams (mg) and Benadryl 50 mg were given intramuscular (IM) prior to departure from the Facility, but no IPN was found indicating why it was given, when this was given, where given, and/or his response to it. He was admitted to hospital.

k. Medication variances were not properly reported for Individual #65, and Individual #19.

l. Individual #145, and Individual #62 had medication variances that required follow-up orders, which were followed. For Individual #65, and Individual #19, it was unclear whether or not orders were needed.

Physical and Nutritional Management

Outcome 1 – Individuals’ at-risk conditions are minimized.		
Compliance rating:		
#	Indicator	Score
a.	Individuals the PNMT has seen for PNM issues show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	

	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	13% 1/8
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	13% 1/8
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/8
	iv. Individual has made progress on his/her goal/objective; and	0% 0/8
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/8
b.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:	
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9
	ii. Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions;	0% 0/9
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9

Comments: a. The Monitoring Team reviewed eight areas of need for five individuals that met criteria for PNMT involvement, including: aspiration, and weight for Individual #112; aspiration for Individual #65; aspiration, and circulatory for Individual #19; skin integrity, and weight for Individual #62; and aspiration for Individual #126, who died on 3/20/15, but had no goals/objectives related to his high risk for aspiration. Working in conjunction with the individual's IDTs, the PNMT had developed clinically relevant, achievable, and measurable goals/objectives for Individual #112.

b.i. and b.ii. The Monitoring Team reviewed nine goals/objectives related to PNM issues that six individuals' IDTs were responsible for developing. These included goals/objectives related to: choking for Individual #65; choking, and weight for Individual #145; falls for Individual #126; choking for Individual #92; choking, and aspiration for Individual #2; and choking, and falls for Individual #138. None of the goals/objectives were clinically relevant, achievable, and measurable.

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

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

Compliance rating:

#	Indicator	Score
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	6% 1/17

b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	0% 0/11
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/3
<p>Comments: a. As noted above, most IHCPs did not include all of the necessary action steps to meet individuals' needs. In addition, the timeframe and/or criteria for the completion of actions steps were often vague, and, as a result, there was no way to measure their completion. The one exception was the action plan related to choking for Individual #92.</p> <p>b. For the individuals reviewed, IDTs did not address changes of status in a timely manner related to aspiration, and weight for Individual #112; aspiration, and choking for Individual #65; weight for Individual #145; aspiration for Individual #126; aspiration, and circulatory for Individual #19; skin integrity, and weight for Individual #62; and falls for Individual #138. The following provide some examples of concerns noted:</p> <ul style="list-style-type: none"> Individual #65 did not have appropriate and timely assessment of physical and nutritional management needs related to the frequent emesis and aspiration risk, and there had been a delay in finally obtaining a needed modified barium swallow study. As the Monitoring Team indicated in correspondence to the State after the onsite visit, PNMT proceedings undertaken during the week of the Monitoring Team's visit must be continued and incorporated into the overall comprehensive assessment process. The Facility responded that: "PNMT will complete a comprehensive assessment within two weeks. This will include an SLP, Dietary, PT, Psychology, and Psychiatric Assessment. Habilitation will update the PNMP to include the hospital bed to be at 30 degrees when resting and 60 degrees after his meals. The hospital bed was placed on 8/18/15. After placement, the PNMT Nurse and PT reported to the IDT that there were no incidents of emesis noted." Individual #112 was not referred to the PNMT until he experienced three incidences of aspiration pneumonia, and he was not referred to address his significant weight loss (i.e., over 10% in three months). Individual #19 was ambulatory in April 2015, and at the time of the Monitoring Team's review was using a wheelchair. However, her team did not appear to be addressing this significant change in status. In addition, her position in her wheelchair did not meet her needs. <p>c. There was no evidence of a discharge summary, or ISPA for discharge from the PNMT for skin integrity, and weight for Individual #62; or aspiration for Individual #126.</p>		

Outcome 5 – Individuals' PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.		
Compliance rating:		
#	Indicator	Score
a.	Individuals' PNMPs are implemented as written.	43% 16/37
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.	40% 4/10
<p>Comments: a. The Monitoring Team conducted 37 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during zero out of two observations (0%). Staff followed individuals' dining plans during 11 out of 29 mealtime observations (38%). Transfers were completed according to the PNMPs in five of six observations (83%).</p>		

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/7
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/7
d.	Individual has made progress on his/her OT/PT goal.	0% 0/7
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/7
<p>Comments: a. and b. For five individuals reviewed, seven goals/objectives and/or areas of need related to OT/PT services and supports were reviewed (i.e., Individual #112 had no goal for reconditioning after a significant change in status; Individual #19 had three PT goals, but a current ISP was not submitted; Individual #62 had no goal to address regression and loss of strength; Individual #92 had no goal, but the comprehensive assessment identified issues related to motor performance; and Individual #126 for his standing table). None of these goals/objectives were clinically relevant and achievable, measurable, and included in the ISP/IHCP.</p> <p>c. through e. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.</p>		

Outcome 4 – Individuals’ ISP plans to address their OT/PT needs are implemented timely and completely.		
Compliance rating:		
#	Indicator	Score
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	50% 1/2
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/1
<p>a. As noted above, assessments and/or action plans were not completed for individuals reviewed, or they did not provide measurable strategies by which to measure implementation. As a result, review of their completion was generally not possible. The one program for which data sheets were available was Individual #126’s standing program. Progress notes were written for Individual #19, but there was no corresponding program/goals/objectives in her ISP (i.e., none was submitted).</p> <p>b. For Individual #126’s standing program, there was no ISPA meeting documentation to show that the IDT discussed and approved its discontinuation. Moreover, the PT provided no rationale for discontinuing it.</p>		

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.		
Compliance rating:		
#	Indicator	Score
a.	Assistive/adaptive equipment identified in the individual’s PNMP is clean.	100%

		9/9
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	89% 8/9
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	44% 4/9
<p>Comments: a. and b. The Monitoring Team conducted observations of nine pieces of adaptive equipment. The individuals the Monitoring Team observed generally had clean adaptive equipment that was in working order, which was good to see. The exception to working condition was the helmet for Individual #11. His helmet bounced around on his head and slid around backwards. It had no strap, which staff reported he could not use. However, because the helmet was reportedly used for "bumping his head," it did not appear to provide the protection he needed.</p> <p>c. Issues with proper fit were noted with regard to the helmet for Individual #11 (i.e., as discussed above), and lift vest for Individual #143, which also likely was not the least restrictive alternative. Proper fit issues also were noted with the wheelchairs for Individual #140, Individual #112, and Individual #19. Based on observation of each of these individuals, the outcome was that they were not positioned correctly in their wheelchairs. It is the Facility's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly. Of note:</p> <ul style="list-style-type: none"> • For Individual #140, her PNMP indicated that the wheelchair should be used for long distances and to alternate with the Merry walker or when fatigued. Staff reported she could not walk now. A picture of the Merry walker was not on the PNMP, and staff were not aware of it. Her wheelchair was a sling seat and back, which was improper for good posture for extended use. She wore a lift vest while seated. Staff stated that she wore ankle foot orthosis, because she could not walk any more rather than as an assist for walking. • Individual #19 was very flexed forward in the chair with her chest and head on the padded tray. Her legs were extended. By report, staff were supposed to raise and lower her legs every 30 minutes per PT and every 15 minutes per Retirement Center staff, but this was not noted at any time she was observed). It did not appear that her hips were adequately placed back in the seat. • Individual #112's wheelchair appeared too wide and the seat depth appeared short. It was also a sling seat and back, so did not provide adequate support for posture. 		

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

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.		
Compliance rating:		
#	Indicator	Score
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6
5	If personal goals were met, the IDT updated or made new personal goals.	N/A
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6
7	Activity and/or revisions to supports were implemented.	0% 0/4
<p>Comments: Once Rio Grande develops individualized personal goals, it is likely that actions plans will be developed to support the achievement of those personal goals and, thus, the facility can achieve compliance with this outcome and its indicators.</p> <p>4. Regarding action plans, for this group of individuals, personal goals were not consistently well defined. For all individuals, progress was negatively impacted by action plans that were not implemented on a timely basis, if at all, or consistently implemented once in place.</p> <p>6. Revisions to supports did not generally occur when individuals were not making progress. For example:</p> <ul style="list-style-type: none"> • For Individual #65, there was no progress in his bathing SO for many months, and a recommended bathing SAP to address the lack of progress was never implemented. • For Individual #65 and Individual #112, there were lengthy delays in responses to behavioral health department referrals for revisions to behavioral supports. 		

Outcome 9 – ISPs are implemented correctly and as often as required.		
Compliance rating:		
#	Indicator	Score
42	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6
43	Action steps in the ISP were consistently implemented.	0% 0/6
<p>Comments:</p> <p>42. Overall, staff interviewed by the Monitoring Team did not appear to be knowledgeable of the specific action plans in each individual’s ISP.</p> <p>43. There were many instances of failure to implement action plans or provide timely follow-up.</p>		

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.		
Compliance rating:		
#	Indicator	Score
6	The individual is progressing on his/her SAPS	36% 8/22
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/4
8	If the individual was not making progress, actions were taken.	29% 4/14
9	Decisions to continue, discontinue, or modify SAPs were data based.	36% 8/22
<p>Comments:</p> <p>6. A determination of progress could be made for 22 of the 25 SAPs. The Monitoring Team was unable to assess if progress was being made on the other three SAPs (Individual #34's play soccer SAP, Individual #112's hold the telephone SAP, Individual #77 weigh paper SAP) because three or more months of data were not available to review. Eight of the 22 SAPs (36%) were judged to be making progress.</p> <p>7. Four SAP objectives appeared to be met, however, all of these SAPs (Individual #44's budgeting SAP, Individual #98's selecting activities and greeting peers SAPs, Individual #97's apply hand sanitizer SAP) were continued.</p> <p>8-9. Similarly, in 29% of the SAPs that were not progressing (e.g., Individual #97's passing the object SAP), was there evidence that actions were taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP). Overall, there were data based decisions to continue, discontinue, or modify SAPs (e.g., Individual #65's identifying medication SAP was changed due to a lack of progress) in 36% of the SAPs.</p>		

Outcome 4- All individuals have SAPs that contain the required components.		
Compliance rating:		
#	Indicator	Score
13	The individual's SAPs are complete.	0% 0/25
<p>Comments:</p> <p>13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the 25 SAPs were complete. A common missing component was the absence of clear instructions on how to conduct the SAP.</p> <p>All SAPs indicated that they utilized forward chaining, backward chaining, total task, or shaping training procedures. None of the SAPs, however, described the differences among these training methodologies. Further, neither the staff implementing the SAPs nor the SAP trainer interviewed by the Monitoring Team, understood the differences associated with these different training procedures.</p> <p>Another common problem was the absence of documentation instructions. For example, Individual #112's turn on the radio SAP training sheet indicated that this SAP was trained using backward chaining. In backward training, the training starts with the last step in the task analysis and moves up the chain of behaviors as the individual masters each training step. There was, however, no indication of what the training step was. The DSP implementing the SAP did not know what the training step was and, therefore, did not know what to record.</p>		

Another common missing component was reinforcement for correct responding. Several SAPs indicated that the target behavior would be the reinforcer. For example, Individual #104's select an activity SAP training sheet said that Individual #104 having the opportunity to engage in the activity he selects is the reinforcer. Having powerful motivation (a potent reinforcer) is one of the most important components of an effective SAP. If accessing the activity was a potent reinforcer for Individual #104, then he likely would not need a skill acquisition plan to learn how to access it.

Other SAP components commonly missing were task analysis (e.g., Individual #97's take the money SAP), generalization and maintenance plans (Individual #44's tooth brushing SAP), and the absence of clear guideline for how often training (both formal and informal) should occur (e.g., Individual #36's SAP of asking for help).

Outcome 5- SAPs are implemented with integrity.

Compliance rating:

#	Indicator	Score
14	SAPs are implemented as written.	0% 0/2
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% 0/25

Comments:

14. The Monitoring Team observed the implementation of two SAPs. Individual #77's turn on the radio SAP and Individual #97's passing the ball SAP. Both were not implemented with integrity. As discussed above, most likely due to unclear instructions, the SAP and data collection were not implemented with consistency.

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

Outcome 6 - SAP data are reviewed monthly, and decisions to continue, discontinue, or modify SAPs are data based.

Compliance rating:

#	Indicator	Score
16	There is evidence that SAPs are reviewed monthly.	92% 23/25
17	SAP outcomes are graphed.	28% 7/25

Comments:

16. SAP outcomes were reviewed in the QIDP monthly reviews (the exceptions were Individual #77's weigh paper SAP and Individual #34's play soccer SAP). Additionally, these reviews typically included SAP data (Individual #112's SAPs being the exception).

17. Seven of the 25 SAPs (28%) were regularly and adequately graphed.

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

Compliance rating:

#	Indicator	Score
18	The individual is meaningfully engaged in residential and treatment sites.	11% 1/9
19	The facility regularly measures engagement in all of the individual's treatment	100%

	sites.	9/9
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9
<p>Comments:</p> <p>18. The Monitoring Team directly observed all nine individuals a number of times in various settings on campus during the onsite week. The Monitoring Team found one of the nine individuals (Individual #77) to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).</p> <p>19-21. Rio Grande regularly conducted engagement measures in the residential and day programming sites. Although the facility's scores (based on monthly data collected in each individual's residence and day program) were somewhat higher than those of the Monitoring Team, their engagement goal was much higher than the Monitoring Team's and, therefore, none met the facility's engagement goal.</p>		

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.		
Compliance rating:		
#	Indicator	Score
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9
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
<p>Comments:</p> <p>22-24. There was evidence that all of individuals participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved.</p> <p>Typically, Rio Grande State Center did not collect data concerning the implementation of SAPs in the community (Individual #97 was the exception). SAP training data and a goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.</p>		

Outcome 9 – Students receive educational services and these services are integrated into the ISP.		
Compliance rating:		
#	Indicator	Score
25	The student receives educational services that are integrated with the ISP.	0% 0/3
<p>Comments:</p> <p>25. Three of the individuals (Individual #44, Individual #34, Individual #104) were under 22 and were receiving educational services from the local independent school district last school year. The facility worked with the school district to provide appropriate educational services for all three students. This was good to hear about. The IEP, however, was not clearly integrated in the ISP for any of the students.</p>		

Dental

Outcome 2 – Individuals with a history of refusals cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions;	0% 0/3
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3
<p>Comments: a. and b. The Monitoring Team reviewed three individuals with a history of refusals to cooperate with dental care (i.e., Individual #145, Individual #92, and Individual #2). None of them had goals/objectives that were clinically relevant and achievable, or measurable and time-bound.</p> <p>c. through e. Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services to these individuals.</p>		

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.		
Compliance rating:		
#	Indicator	Score
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/4
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/4
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/4
d.	Individual has made progress on his/her communication goal(s)/objective(s).	
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/4
<p>Comments: a. and b. The Monitoring Team reviewed four communication-related goals/objectives and/or areas of need for four individuals (i.e., Individual #62, Individual #19, Individual #92, and Individual #126). None of these individuals had goals that were clinically relevant, achievable, measurable, and included in their ISPs.</p> <p>c. through e. Overall, in addition to a lack of measurable goals/objectives, progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress</p>		

was not occurring, that the IDTs took necessary action.

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

Compliance rating:

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A

Comments: a. As noted above, quite unfortunately, communication assessments and/or action plans were not completed for individuals reviewed, or they did not provide measurable strategies by which to measure implementation. As a result, review of their completion was generally not possible. Individual #19 had a program related to choice-making using a device. The monthly notes provided related to the previous year's ISP, and data was not included for this program.

Outcome 5 - Individuals functionally use their AAC and EC systems/devices, and other language-based supports in relevant contexts and settings, and at relevant times.

Compliance rating:

#	Indicator	Score
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	100% 5/5
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	80% 4/5
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	100% 3/3

Comments: a. and b. The Monitoring Team conducted five observations of individuals with AAC/EC systems or devices, including: Individual #97 - two observations, Individual #86, Individual #118, and Individual #19. It was positive that all individuals had their devices, and most were using them. The individual that was not noted to be using his device or language-based support was: Individual #86, and staff did not prompt its use.

c. It was very positive that staff assigned to work with individuals with whom the Monitoring Team spoke were able to demonstrate or describe the use of the devices.

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

Domain #6: Individuals in the Target Population will receive services in the most integrated setting, with the frequency, intensity, and duration necessary to meet their appropriately identified needs, consistent with their informed choice.

To repeat from the “Background” section at the beginning of this report, the outcomes and indicators for monitoring each SSLC’s quality assurance program and some aspects of the facility’s most integrated setting practices were not finalized. This was due to the State and DOJ’s continued discussions regarding the most integrated setting practices, and the State’s efforts to completely revise its quality assurance system. Therefore, outcomes, indicators, and scores for Domains #5 and #6 were not completed for this review.

<p>SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management</p>	
<p>Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.</p>	<p>Steps Taken to Assess Compliance:</p> <p><u>Documents Reviewed:</u></p> <ol style="list-style-type: none"> 1. RGSC Self-Assessment 7/10/15 2. DADS Policy 021.4 Protection From Harm - Abuse, Neglect, and Exploitation (6/5/15) 3. DADS Policy 002.5 Incident Management (11/5/13) 4. DADS State Supported Living Center Procedure: Injury Audits (3/20/13) 5. RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation (7/15) 6. RGSC SOP ICF-IID 200-03 Incident Management (11/13) 7. RGSC SOP ICF-IID 400-01 Injuries to Consumers (7/12) 8. Unusual incident and serious injury logs 1/1/15 to 8/10/15 9. DFPS Investigation case log 1/1/15 to 8/10/15 10. Self-Advocates meeting minutes 4/15/15, 5/15/15, 6/15/15 11. Meeting minutes: DFPS/OIG/RGSC Quarterly Coordination meetings held 3/4/15 and 6/3/15 12. Injury Audit Record Reviews for January 2015 through June 2015 13. Secondary Investigation Audits for January 2015 through June 2015 14. Sample D.1: included a sample of 10 DFPS investigations of abuse, neglect, and/or exploitation (with the companion Facility UIRs, investigation review documents, and related documentation). This represented 100% of DFPS investigations that had occurred between 1/1/15 and the preparation of the document request for this review. These 10 investigations included allegations of abuse and neglect, and resulted in confirmed, unconfirmed, and inconclusive findings. Investigation records were for cases: 43544720, 43518060, 43655338, 43595017, 43611853, 43678209, 43589677, 43561161, 43728042, and 43648141 15. Sample D.2: included a sample of three facility-only investigations selected from the log of serious injuries and incidents between 1/1/15 and the preparation of the document request for this review. The sample represented three of 10 (30%) facility-only investigations. Investigation records included UIRs 15-010, 15-011, and 15-012. 16. Incident Management Review Team (IMRT) minutes for meetings associated with investigation Samples D.1 and D.2 17. Sample D.3: ISPs for Individuals named as Alleged Victims in Sample D.1 (Individual #41,

	<p>Individual #36, Individual #18, Individual #89, Individual #140, Individual #44, Individual #138, and Individual #34)</p> <p>18. Sample D.4: training records for 20 randomly selected direct support professionals.</p> <p>19. Sample D.5: 12 direct support staff randomly selected for assessing staff knowledge of ANE policy requirements</p> <p><u>People Interviewed:</u></p> <ol style="list-style-type: none"> 1. Myrna Wolfe, Incident Management Coordinator (IMC) 2. Vanessa Alvarez, Human Rights Officer 3. Selena Whittinghill, Primary Investigator 4. Juan Miguel Gonzalez, Program Improvement Manager (IMRT Chair) 5. Mary Ramos, Quality Management Director 6. Richard Hawkins, APS (DFPS) Investigator 7. George Elizondo, Internal Affairs Investigator (OIG) 8. Benjamin Perez, Jr., Competency Training & Development (CTD) Director 9. 12 Direct Support Professionals <p><u>Meetings Attended:</u></p> <ol style="list-style-type: none"> 1. Incident Management Review Team (IMRT) 8/10/15 and 8/13/15 2. Human Rights Committee 8/13/15 3. Settlement Agreement Performance Improvement Council (SA-PIC) 8/13/15 <hr/> <p>Facility Self-Assessment:</p> <p>The RGSC Self-Assessment prepared in advance of this review reported that the Facility was in substantial compliance with 22 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with all 22.</p> <p>In its Self-Assessment, for each provision, the Facility had identified: (1) activities engaged in to conduct the self-assessment, (2) the results of the self-assessment, and (3) a self-rating. For Section D, in conducting its self-assessment, the Facility had, as it had done in prior reviews:</p> <ol style="list-style-type: none"> 1. Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: <ol style="list-style-type: none"> a. The monitoring/audit tools the Facility used to conduct its self-assessment included the
--	---

	<p>RGSC Quality Review tool on the Completeness of UIRs, ANE Competency Audit form, Unusual Incident Investigation Review Checklist, UIR Audit Tool, Audit of Implementation of UIR Recommendations, and CAP Effectiveness Audits.</p> <ol style="list-style-type: none"> b. These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. c. The monitoring tools included adequate methodologies, such as observations, interviews, and record reviews. d. The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). For the most part sample sizes were either 20% of the N or 100% samples. e. The monitoring/audit tools did not always have adequate written instructions/guidelines to ensure consistency in monitoring and the validity of the results, however, many of these tools were administered by one unique staff member, which would tend to ensure consistency in application. f. The following staff/positions were responsible for completing the audit tools: QE Coordinator, Incident Management Coordinator, Human Rights Officer, Health Information Management staff, and Program Specialists/Campus Coordinators. g. The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant areas. h. Some degree of inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools, however, inter-rater reliability data were not presented in the self-assessment. <ol style="list-style-type: none"> 2. The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: <ol style="list-style-type: none"> a. Presented findings consistently based on specific, measurable indicators and used these data in initiating corrective actions b. Consistently measured the quality as well as presence of items. 3. The Facility rated itself as being in compliance with all 22 provisions of Section D. The Monitoring Team agreed, finding the Facility to be in compliance with all 22 provisions.
--	---

Summary of Monitor’s Assessment:

In its last review the Monitoring Team found the Facility to be in compliance with 22 out of the 22 provisions of Section D and this continued to be the case. This was the third consecutive review where the Facility was found to be in substantial compliance with all 22 provisions of Section D of the Settlement Agreement.

Reporting of allegations of abuse/neglect and unusual incidents were, for the most part, timely and in accordance with policy requirements. In the instances where reporting was not timely, the Facility self-identified the problem and took appropriate and timely administrative action with the offending employee.

Staff had completed required training within the preceding 12 months.

The DFPS and OIG Investigators interviewed expressed a high level of cooperation between Facility administrative staff and themselves. The Facility had made office space available to DFPS and OIG, and DFPS and OIG had an investigator working out of this office on a regular basis. This facilitated timely communication between the Facility and DFPS/OIG. In the last Monitoring Team review (one year ago), both investigators reported concern about feared retaliation expressed by some staff in the course of interviews. During this review, they both reported these concerns had been addressed by Facility administration and staff interviewed no longer expressed concerns with retaliation.

The DFPS and OIG Investigators interviewed expressed that Facility staff (primarily alleged perpetrators and collateral witnesses) were cooperative in their interviews and any other investigatory activity.

The internal management and monitoring systems in place at RGSC continued to self-identify instances of noncompliance with policy and procedure, especially in areas where clear data parameters existed, such as the timeframes associated with reporting, initiating investigations, and completing investigations. Issues were immediately addressed when identified. During this review, the Monitoring Team did not detect any instances of noncompliance with policy and procedure that the Facility had not already detected.

The Incident Management Review Team (IMRT) process was in place and functioned as a review body, met daily, and its minutes were detailed and reflected review of injuries, incidents, and investigation reports.

The Facility’s policies and procedures included a commitment that abuse and neglect of individuals would not be tolerated, and required that staff report abuse and/or neglect of individuals. Staff knowledge of these requirements was very good. Staff knowledge of signs and symptoms of abuse/neglect was also very

	<p>good.</p> <p>Through the course of reviewing investigations, the Monitoring Team noted that the video surveillance cameras continued to be helpful in ascertaining the facts associated with many allegations.</p> <p>The Facility process for the review of non-serious discovered injuries (to rule out abuse and/or neglect) continued to represent best practice.</p> <p>Self-advocate meetings were held monthly and were well attended. Abuse and neglect reporting was regularly reviewed as a means of providing ongoing education to individuals.</p> <p>Presentation of information in UIRs continued to be well organized, flowed in a logical manner, and ensured that all the requirements of the Settlement Agreement could be easily identified to determine compliance.</p> <p>Facility review of investigations ensured that the investigations were thorough and complete and that reports were accurate, complete, and coherent. If an allegation made to DFPS was returned to the Facility as an administrative referral or with an inconclusive finding, the Facility followed up with a comprehensive thorough investigation of its own.</p> <p>The tracking system for UIR recommendations (to assign responsibility for follow-up disciplinary and programmatic action and monitor the intended actions through completion) continued to be detailed and well organized, usually using the Quality Assurance Department’s Corrective Action Plan system. Tracking and trending data were complete and were regularly analyzed resulting in Corrective Action Plans (CAPs) when appropriate. CAP implementation was tracked to completion and CAPs were assessed for effectiveness.</p>
--	---

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	<p>The Monitoring Team confirmed that policies that had been in place at the time of previous reviews to address this provision remained in place and continued to be the basis for staff training.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	<p>According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, staff were required to report abuse, neglect, and exploitation within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement.</p> <p>With regard to serious incidents, Facility policy RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, required staff to report serious incidents to the Facility Director/designee within one hour of discovery. This policy was consistent with the requirements of the Settlement Agreement.</p> <p>In order to evaluate staff knowledge in the area of incident reporting, 12 Direct Care staff (Sample D.5) were asked a series of questions. The 12 staff were randomly selected by the Monitoring Team. The questions used in assessing staff knowledge were identical to the questions used by the Facility in the monthly competency checks conducted by the Facility Human Rights Officer. Based on responses to questions, 12 direct support professionals provided satisfactory responses to the following questions:</p> <ol style="list-style-type: none"> 1. “There are two representatives that should be contacted immediately if you suspect or witness abuse/neglect/exploitation (ANE). Name them.” All 12 staff (100%) provided a satisfactory response to this question. 2. “You must report within ___ of discovering or suspecting abuse, neglect, and exploitation.” All 12 staff (100%) provided a satisfactory response to this question. 3. Name two types of serious/unusual incidents (other than ANE) that must be reported.” All 12 staff (100%) provided a satisfactory response to this question. 4. What is the reporting procedure and timeframe for serious/unusual (other than 	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		<p>ANE) incidents?" All 12 staff (100%) provided a satisfactory response to this question.</p> <p>The Facility had a process for checking staff competencies. Each month, 10 staff, randomly selected, were quizzed by the Human Rights Officer (HRO). Data collected on these competency checks were maintained and a monthly summary was prepared and presented to the QA Director and the SA-PIC. These audits showed compliance rates ranging from 94% to 99%. In its last report, the Monitoring Team found compliance rates consistently being 100% and suggested that the Facility should review its competency testing methodology to ensure it achieved accurate results. This had occurred and the HRO was applying more rigid standards in her quizzing of staff. If, in the course of these monthly competency checks, on the spot retraining was needed for a particular staff, the HRO provided it. In some cases, the HRO required that a particular staff retake the formal training class on Abuse/Neglect.</p> <p>Based on a review of the 10 investigation reports included in Sample D.1:</p> <ul style="list-style-type: none"> • Nine (90%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within the timeframes required by DADS/Facility policy. <ul style="list-style-type: none"> ○ This was not the case for investigation 43589677. For investigation 43589677, it appeared that a staff person who witnessed an apparent inappropriate interaction between a staff person and an individual at 6 pm did not report this until 11:22 am the next day. The facility, through its investigation review process, identified the late reporting and took appropriate and timely administrative action with the offending employee. • Eight (80%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the Facility Director as required by DADS/Facility policy. This was not the case for investigations 43589677 and 43728042. <ul style="list-style-type: none"> ○ For investigation 43589677, as noted above, it appeared a staff person who witnessed an apparent inappropriate interaction between a staff person and an individual at 6 pm, did not report this until 11:22 am the next day. It was then immediately reported to the Facility Director/designee, however, this was considered late reporting because it did not occur within one hour of the time of the alleged abuse. 	

#	Provision	Assessment of Status	Compliance
		<ul style="list-style-type: none"> ○ For investigation 43728042, the alleged incident was reported to DFPS timely, but the reporter apparently did not also report the incident to the Director/designee. It was reported to the Director/designee immediately after DFPS notified the Facility of the allegation. In both cases, the Facility identified the late reporting and took appropriate and timely administrative action with the offending employees. <p>Based on a review of three investigations included in Sample D.2:</p> <ul style="list-style-type: none"> • All three (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. • All three (100%) included evidence that unusual/serious incidents were reported to the appropriate party (DADS central office) as required by DADS/Facility policy. <p>In summary, Samples D.1 and D.2 show that nine of 10 incidents were reported timely to DFPS, 11 of 13 were reported timely to the Facility Director, and three of three were reported timely to DADS for an overall score of 23 of 26 (89%). In the instances where timely reporting did not occur, the Facility self-identified the issue and took appropriate and timely administrative action to address the problem.</p> <p>The Facility did have a standardized reporting format. Based on a review of 13 investigation reports included in Samples D.1 and D.2, 13 (100%) contained a copy of the report utilizing the required standardized format and were completed fully.</p> <p>In its last review, the Monitoring Team interviewed two Security Camera Monitors to confirm their training in abuse/neglect and unusual incidents and their acknowledgement that identifying and reporting questionable interactions between staff and individuals as possible abuse or neglect was within their scope of responsibilities. This was the case for both, one of whom worked the day shift and one of whom worked the night shift. In reviewing investigations during this review, it was apparent Security Camera Monitors had both reported some allegations, and were witnesses in others.</p> <p>Finally, in previous reports, the Monitoring Team noted that the Facility had engaged in improved practices in its review activity of non-serious discovered injuries to ensure they were not significant and, therefore, should have merited official investigation via the UIR process, or should have been reported to DFPS because of a suspicion of abuse or neglect.</p>	

#	Provision	Assessment of Status	Compliance
		<p>The Facility had implemented a system whereby the Facility’s Human Rights Officer (HRO) reviewed the residential unit’s review of non-serious discovered injuries. These were referred to as Secondary Investigation Audits. The unit investigations consisted of a “Discovered Injury Preliminary Investigation” and a “Discovered Injury Secondary Investigation.” In conducting Secondary Investigation Audits, the HRO reviewed a sample of 20% of the non-serious discovered injury investigations completed by unit staff (Discovered Injury Preliminary Investigation and Discovered Injury Secondary Investigation). These injury investigations were randomly selected by the HRO. This process was used instead of the Non-Serious Injury (NSI) Investigation process established by DADS and was accepted by DADS as an acceptable alternative.</p> <p>The Monitoring Team reviewed the six most recent months of Secondary Investigation Audits completed by the HRO and found them very complete and thorough. Of the 45 audits completed during this six month period, 40 unit investigations were found to be complete and acceptable. Five (11%) were returned to the unit for additional investigation and review of the circumstances associated with the discovered non-serious injury. This represented considerable improvement from data reported by the Monitoring Team in its last report which showed 93% of unit investigations being incomplete and requiring further work by the unit. For this review the Monitoring Team reviewed source documents for a eight of these 45 audits and found them to be accurate and complete. The process for review of discovered non-serious injuries at the RGSC was exemplary and should be considered best practice. The Facility is to be commended for continuing this process as it demonstrates commitment to client protection.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals	According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, the Facility was required to immediately remove any alleged perpetrator of abuse or neglect from contact with individuals, placing the affected staff in NDC (no direct contact) status. Additionally, the Facility was to take immediate client protection steps with the affected individuals, such as conducting a nursing assessment and an emotional assessment.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	<p>involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well-supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.</p>	<p>Based on a review of 10 investigation reports included in Sample D.1, in eight cases, an alleged perpetrator was named. In all eight (100%), the alleged perpetrator was removed from direct contact with individuals immediately following the Facility becoming aware of the allegation.</p> <p>Based on a review of investigation files included in Sample D.1, in no case was a staff person who had been removed from direct contact subsequently reinstated prior to the completion of the investigation, including review of the investigation findings by the Facility.</p> <p>Based on a review of the 10 investigation files, it was documented that adequate additional action had been taken to protect individuals in all 10 cases (100%). Actions included, for example, medical care, emotional assessments, reassignment of roommates, and immediate retraining for staff.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
	<p>(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.</p>	<p>The Monitoring Team reviewed staff development training transcripts of a random sample of 20 employees (Sample D.4). The training transcripts showed 20 of 20 employees (100%) had completed the Abuse/Neglect (ABU0100) class within the last 12 months and 20 of 20 (100%) had completed the Unusual Incidents (UNU0100) class within the last 12 months.</p> <p>These data were consistent with data reported in the Facility self-assessment (which came from monthly audits) that generally showed a high rate of compliance.</p> <p>Additionally, in order to evaluate staff knowledge in the area of abuse and neglect, 12 direct support professionals (Sample D.5) were asked two questions regarding signs and symptoms of abuse and neglect. The questions used in assessing staff knowledge were identical to the questions used by the Facility in the monthly competency audits conducted by the Facility Human Rights Officer. The 12 staff were randomly selected by the Monitoring Team.</p> <p>Based on responses to questions, 12 direct support professionals provided satisfactory</p>	<p>Substantial Compliance</p>

#	Provision	Assessment of Status	Compliance
		<p>responses to the following questions as follows:</p> <ol style="list-style-type: none"> 1. "Name two signs or symptoms of abuse." All 12 staff (100%) provided a satisfactory response to this question. 2. "Name two signs or symptoms of neglect." All 12 staff (100%) provided a satisfactory response to this question. <p>The Facility had a process for checking staff competencies. Each month, 10 staff, randomly selected, were quizzed by the Human Rights Office (HRO). Data collected related to these competency checks was maintained and a monthly summary was prepared and presented to the QA Director and the SA-PIC. These audits showed compliance rates ranging from 94% to 99%. In its last report, the Monitoring Team found compliance rates consistently being 100% and suggested that the Facility should review its competency testing methodology to ensure it achieves accurate results. This had occurred and the HRO was applying more rigid standards in her quizzing of staff. If on the spot retraining was needed as a result of a staff responses, the HRO provided it.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
	<p>(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or</p>	<p>The Monitoring Team reviewed the acknowledgment form required by DADS (Form 1020) for 20 employees (Sample D.4). Valid 1020s were available for all 20 (100%).</p> <p>There were no instances where a mandatory reporter failed to report abuse/neglect, but there were two instances where reporting was not timely (see provision D.2.a above). In these two cases, the Facility took appropriate and timely administrative action with the offending employees.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	<p>Substantial Compliance</p>

#	Provision	Assessment of Status	Compliance
	<p>neglect.</p> <p>(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.</p>	<p>The Facility provided information to guardians/LARs in advance of each ISP meeting. This included an Abuse and Neglect pamphlet that noted the signs and symptoms of abuse and neglect and how to report allegations or suspicions of abuse or neglect. The individuals were also presented with this information by the QIDP before the annual ISP.</p> <p>The topic of abuse/neglect reporting was covered at each ISP meeting and was documented in each ISP. This was validated by the Monitoring Team by reviewing the ISPs (Sample D.3) for individuals who were named as alleged victims in Sample D.1. This was done for Individual #41, Individual #36, Individual #18, Individual #89, Individual #140, Individual #44, Individual #138, and Individual #34.</p> <p>Additionally, the Facility's Human Rights Officer had a standing agenda in her Self Advocacy meetings to educate individuals on how to identify abuse and neglect, how to report it, and who to ask for assistance in reporting abuse or neglect. Also, the ICF-Director met with the Parents Association to disseminate ANE and UI information, including how to identify it and how to report it.</p> <p>Finally, in reviewing DFPS investigations (Sample D.1), the Monitoring Team identified instances where either a guardian or an individual was the reporter of the allegation. This suggested that the Facility's efforts were achieving the desired outcome.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
	<p>(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.</p>	<p>The Monitoring Team conducted inspections of the living areas and the on-campus workshop and found posters in place.</p> <p>Additionally, the Facility had a regular monthly process of inspections to ensure posters were in place. The results were regularly presented to the Facility QA Department for inclusion in regular reporting to the Settlement Agreement Program Improvement Council (QAQI Committee).</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	<p>In reviewing Sample D.1 (DFPS investigations) referral to law enforcement occurred in every case where it was appropriate to do so.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	<p>According to RGSC SOP ICF-IID 200-08 Protection from Harm – Abuse, Neglect, and Exploitation, retaliation against reporters of abuse/neglect was prohibited and not tolerated. Based on interviews with the Facility administrative staff, these requirements were included in training curriculum, reinforced using postings throughout the Facility, and would not be tolerated. Facility administrative staff reported there were no reports made to the Facility of actual or perceived retaliation during this review period.</p> <p>Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns expressed related to actual or perceived retaliation.</p> <p>Twelve Direct Care Professionals were asked if retaliation did happen, or was suspected, should it be reported. All 12 answered yes. If so, to whom? All 12 answered correctly (to the Facility Director).</p> <p>Finally, in its last report, the Monitoring Team noted that outside investigators (DFPS and OIG) reported concerns with perceived or actual retaliation in the course of their interviews with witnesses and suggested that the Facility needed to be more proactive in educational efforts regarding retaliation, including mechanisms to ensure protection of staff who report allegations. This had occurred and both the DFPS and OIG investigators reported that concerns of retaliation had diminished significantly. Neither investigator could even recall the last time they encountered this issue.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are	The Facility policy and/or procedures defined sufficient procedures to audit whether significant injuries of a sample of individuals were reported for investigation. This was conducted by the HIM Department. Audits were done monthly, averaging three audits per	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	reported for investigation.	<p>month. Seventeen audits (25% of Facility census) were completed between January 2015 and June 2015.</p> <p>Facility policy also required a trend review of incidents for a sample of individuals each month. The trend review was conducted by a Facility Investigator and consisted of the same individuals selected for the above noted injury audits. This review examined source documents and was very detailed in looking for any patterns in types of injuries, causes of injuries, correlations of injuries occurring when certain staff were on duty, and whether any issues were detected that should cause an allegation to be referred to DFPS. Seventeen trend reviews had taken place between January 2015 and June 2015 representing 25% of the Facility census.</p> <p>For both processes, results were presented to the Facility QA Department for inclusion in regular reporting to the Settlement Agreement Program Improvement Council (QAQI Committee).</p> <p>The Monitoring Team determined that the audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation and that the trend review was comprehensive and thorough and detected trends when appropriate.</p> <p>No unreported significant injuries were identified by the audits. The audit procedure required by DADS had been in place for some time at RGSC and was being administered correctly. The audits did not discover any significant injuries that were not reported and investigated but should have been.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect,		

#	Provision	Assessment of Status	Compliance
	exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	<p>The Facility provided a list of four DFPS investigators who conducted investigations at the Facility. Training records of all four were reviewed. All four had the required training and were, therefore, deemed qualified. The required training consisted of the Facility Investigations ILSD course and the Facility Investigations ILASD course.</p> <p>The Facility provided a list of nine Facility staff who are authorized to conduct investigations at the Facility. Training records of all nine were reviewed and all nine had the required training and were, therefore, deemed qualified. The required training consisted of the following courses:</p> <ol style="list-style-type: none"> 1. Conducting Serious Investigations (CSI0100) 2. Comprehensive Investigator Training (CIT0100) 3. Root Cause Analysis (RCA0100) 4. People with Mental Retardation (MEN0300) 5. Unusual Incidents (UNU0100) 6. Abuse Neglect (ANU0100) <p>None of the investigations were conducted by an investigator who was in the direct line of supervision of staff subject to the investigation.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	<p>In reviewing Sample D.1 and D.2, the Monitoring Team found no evidence of lack of cooperation between Facility staff and outside entities.</p> <p>During this review, the Monitoring Team interviewed a DFPS investigator and an OIG investigator. Both reported a high level of cooperation from Facility staff.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	<p>In reviewing Sample D.1 and D.2, and from interviews with both a DFPS and OIG investigator, the Monitoring Team was able to determine that coordination of investigations occurred between DFPS and OIG and found no evidence of interference by one party or the other.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	<p>In its review of Sample D.1 and D.2, the Monitoring Team did not detect any issues with the safeguarding of physical evidence.</p> <p>As noted in its previous reports, the Monitoring Team remains concerned that no action had been taken regarding an important provision of State and Facility policy regarding <u>testimonial</u> evidence. The State and Facility policy stated that “in most cases the highest priority will be to identify interviewees and physically separate them until they have been interviewed.”</p> <p>The Monitoring Team found no evidence that this component of the Facility and DADS policy (i.e., separation of witnesses until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations), there was no indication that collateral witnesses had been physically separated pending interview. That being said, as a practical matter, this would be difficult because DFPS usually does not conduct interviews of collateral witnesses or alleged perpetrators (APs) until days after an allegation is reported.</p> <p>In past reports, the Monitoring Team suggested that the Facility and DADS should review current policy with respect to testimonial evidence and that it would be helpful if DADS provided guidance to the Facility as to how this policy should be implemented (or change the policy such that it established requirements that can be reasonably administered).</p> <p>During this review, the Facility reported that since the last review it had initiated conversation with DADs in this regard and learned that the policy was not going to change. No guidance was provided regarding reasonable approaches to comply with this policy.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	<p>(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.</p>	<p>Based on RGSC SOP ICF-IID 200-03 Incident Management, investigations of serious incidents:</p> <ul style="list-style-type: none"> • Were to commence within 24 hours or sooner, if necessary; • Were to be completed within 10 calendar days of the incident; • Did require a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and • Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. <p>To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below; the findings related to the DFPS investigations and the Facility investigations are discussed separately.</p> <p><u>DFPS Investigations</u></p> <p>The following summarizes the results of the review of DFPS investigations:</p> <ul style="list-style-type: none"> • Ten of 10 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following are examples of actions from investigations in which adequate investigatory process occurred within the first 24 hours or sooner, if necessary: telephone contact with the Facility’s Incident Management Coordinator or Campus Coordinator to ensure the individual who was the subject of the report was safe (and, if injured, had received appropriate medical care), that any known APs were placed in NDC status, the identification of any collateral witnesses, that the Facility had (or was) gathering all relevant documentation, that any physical evidence was secure, a determination if there was likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. • Nine of 10 (90%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Investigation 43589677 did not. According to the signature date on the DFPS investigation report, this investigation was completed on day 11. According to the Facility, DFPS attributed this to a technical 	<p>Substantial Compliance</p>

#	Provision	Assessment of Status	Compliance
		<p>glitch, noting that the investigation was in fact completed on day 10, but noted that their computer system was temporarily out of service and they could not enter data.</p> <ul style="list-style-type: none"> • Ten (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • In one case, DFPS included a recommendation which the Facility acted on. This was to develop and implement a PBSP for one individual. <p><u>Facility Investigations</u> The following summarizes the results of the review of Facility-only investigations:</p> <ul style="list-style-type: none"> • Three of three (100%) commenced within 24 hours or sooner. All were commenced within one hour of being reported. The Facility had trained investigators on-duty 24/7. • Three of three (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; • Three (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. • In three (100%) of the investigations reviewed, recommendations for corrective action were included. In all three (100%), the recommendations were adequate to address the findings of the investigation. These typically included one or more IDT follow-ups documented in an ISPA, environmental changes, and when appropriate, personnel actions. <p>In summary, 13 of 13 (100%) of investigations began within the required 24 hour timeframe; and 12 of 13 (92%) were completed within the required 10 day timeframe. All 13 (100%) resulted in an appropriate written report; and all 13 (100%) included recommendations appropriate to the circumstances of the investigation.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	

#	Provision	Assessment of Status	Compliance
	<p>(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.</p>	<p>Based on the Monitoring Team review of DADS revised Policy 021.4 on Protection from Harm – Abuse, Neglect, and Exploitation: Section VII.B, the policy was consistent with the Settlement Agreement requirements.</p> <p>The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports.</p> <p>To determine compliance with this provision of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Sample D.2) were reviewed. The results of these reviews are discussed in detail below. The findings related to the DFPS investigations and the Facility investigations are discussed separately.</p> <p><u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations:</p> <ul style="list-style-type: none"> • In 10 out of 10 investigations (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: <ul style="list-style-type: none"> ○ In 10 (100%), each unusual/serious incident or allegations of wrongdoing; ○ In 10 (100%), the name(s) of all witnesses; ○ In 10 (100%), the name(s) of all alleged victims and perpetrators; ○ In 10 (100%), the names of all persons interviewed during the investigation; ○ In 10 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ○ In 10 (100%), all documents reviewed during the investigation; ○ In 10 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ○ In 10 (100%), the investigator's findings; and ○ In 10 (100%), the investigator's reasons for his/her conclusions. <p><u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations:</p>	<p>Substantial Compliance</p>

#	Provision	Assessment of Status	Compliance
		<ul style="list-style-type: none"> • In three of three investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: <ul style="list-style-type: none"> ○ In three (100%), each unusual/serious incident or allegations of wrongdoing; ○ In three (100%), the name(s) of all witnesses; ○ In three (100%), the name(s) of all alleged victims and perpetrators; ○ In three (100%), the names of all persons interviewed during the investigation; ○ In three (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ○ In three (100%), all documents reviewed during the investigation; ○ In three (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ○ In three (100%), the investigator's findings; and ○ In three (100%), the investigator's reasons for his/her conclusions. <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
	<p>(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.</p>	<p>The Facility policy and procedures did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that (1) the investigation was complete, and (2) the report was accurate, complete, and coherent.</p> <p>The Facility policy did require that any further inquiries or deficiencies be addressed promptly.</p> <p><u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations:</p> <ul style="list-style-type: none"> • The DFPS investigations in Sample D.1 did meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; • Ten of 10 (100%) were reviewed by the Review Authority, which included the Incident Management Coordinator and the Facility Director within five working 	<p>Substantial Compliance</p>

#	Provision	Assessment of Status	Compliance
		<p>days of receipt of the completed investigation.</p> <ul style="list-style-type: none"> The Facility Director/Incident Management Coordinator did accept at least 94 percent of the investigations over the six months prior to the onsite review. <p><u>Facility Investigations</u></p> <p>The following summarizes the results of the review of Facility investigations:</p> <ul style="list-style-type: none"> Three of three (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. Three of three (100%) investigation files reviewed contained evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. For three the supervisor had identified concerns. For these investigations, for three (100%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. <p>In summary, three of three (100%) Facility investigations were reviewed according to the requirements of this provision of the Settlement Agreement and, overall, 13 of 13 (100%) were reviewed according to the requirements of this provision of the Settlement Agreement.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	<p>The Facility-only investigations did meet the requirements outlined in Section D.3.f.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action	<p>The Facility policy and procedures did require disciplinary or programmatic action, necessary to correct the situation and/or prevent recurrence, to be taken promptly and thoroughly. In addition, the policy and procedures did specify the Facility system for tracking and documenting such actions and the corresponding outcomes.</p> <p>For investigations reviewed for Samples D.1 and D.2 in which disciplinary action was</p>	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	promptly and thoroughly, and track and document such actions and the corresponding outcomes.	<p>warranted, prompt and appropriate disciplinary action had been taken and documented in each instance.</p> <p>For investigations reviewed for Samples D.1 and D.2 in which programmatic action was warranted, prompt and appropriate action had been taken and documented in each instance.</p> <p>For investigations in which disciplinary and/or programmatic action was taken, there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified in each instance. This was typically achieved through the use of Corrective Action Plans (part of the Facility's QA system) and was closely monitored through the CAP data base.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	<p>The Facility maintained data bases that allowed for the tracking of incidents/investigations by individual staff names and by names of individuals living at the Facility. Investigation files were maintained in an organized and orderly fashion.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the	<p>The Monitoring Team reviewed documentation to validate that the systems for the tracking and trending of incidents and investigations, and for appropriate administrative follow-up that had been established at the Facility continued to be in place and used effectively.</p> <p>For example, for all categories of unusual incident categories and investigations, the Facility continued to maintain a system that allowed tracking and trending by:</p> <ul style="list-style-type: none"> • Type of incident; • Staff alleged to have caused the incident; • Individuals directly involved; 	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	<p>incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.</p>	<ul style="list-style-type: none"> • Location of incident; • Date and time of incident; • Cause(s) of incident; and • Outcome of investigation. <p>Over the past two quarters, the Facility's trend analyses:</p> <ul style="list-style-type: none"> • Were conducted at least quarterly; • Did address the minimum data elements; • Did use appropriate trend analysis procedures; • Did provide a narrative description/explanation of the results and conclusions; and • Did, as appropriate, contain recommendations for corrective actions. <p>Based on a review of trend reports, IMRT minutes, and SA-PIC (QAQI Council) minutes, when a negative pattern or trend was identified and an action plan was needed, action plans were developed. As appropriate, action plans were developed both for specific individuals and at a systemic level. The trend reports and/or minutes showed that action plans were implemented and tracked to completion. The report/minutes showed review, as appropriate, of the effectiveness of previous action plans.</p> <p>The Facility continued to use its Quality Assurance Department methodology for review of data referred to as CATW2. CATW2 refers to <u>C</u>heck, <u>A</u>sk, <u>T</u>hink, <u>W</u>hy, and <u>W</u>hat. This methodology was developed several years ago by the Facility to encourage those reviewing data reports to engage in critical thinking. Trend data associated with unusual incidents and investigation results was reviewed using this system.</p> <p>Each trend report was reviewed monthly at the SA-Program Improvement Council (the equivalent of a QAQI Council) and subjected to the CATW2 process. There was evidence provided to the Monitoring Team that the Facility regularly evaluated this information and was using it to identify and address perceived systemic issues that may be barriers to protecting individuals from harm.</p> <p>Based on this review, the Monitoring Team determined this provision was in substantial compliance.</p>	

#	Provision	Assessment of Status	Compliance
D5	<p>Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.</p>	<p>The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.</p>	<p>Substantial Compliance</p>

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 1/1/15, with date of admission
- Individuals transitioned to the community since 1/1/15
- Community referral list, as of most current date available
- List of individuals who have died since 1/1/15, 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 over the past six months;
 - Individuals discharged by the PNMT over the last 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 during the past six months and the date of the tube placement;
 - Individuals who are at risk of receiving a feeding tube;
 - During the past six months, individuals who have had a choking incident requiring abdominal thrust, date of occurrence, and what they choked on;
 - During 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;
 - During 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;
 - During the past six months, individuals who have experienced a fracture;
 - During 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;
- 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) over the past six months;
- Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
- Individuals with dental emergencies over the past six months;
- Individuals with Do Not Resuscitate Orders, including qualifying condition; and
- Individuals with adverse drug reactions, including date of discovery.
- Lists of:
 - Crisis intervention restraints.
 - Medical restraints.
 - Protective devices.
 - Any injuries to individuals that occurred during restraint.
 - DFPS cases.
 - All serious injuries.
 - All injuries from individual-to-individual aggression.
 - All serious incidents other than ANE and serious injuries.
 - Non-serious Injury Investigations (NSIs).
 - Lists of individuals who:
 - Have a PBSP
 - Have a crisis intervention plan
 - Have had more than three restraints in a rolling 30 days
 - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
 - Were reviewed by external peer review
 - Were reviewed by internal peer review
 - Were under age 22
 - Individuals who receive psychiatry services and their medications, diagnoses, etc.
- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
 - a. PNMT
 - b. OT/PT and Speech
 - c. Medical
 - d. Nursing
 - e. Pharmacy
 - f. Dental
- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)

- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QA/QI 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
- ISPA's for the last six months
- ISP/IHCP Monthly Reviews from the responsible disciplines for the last six months, including the QIDP monthly reviews/reports
- QDRRs: last two, including the Medication Profile
- Any ISPA's 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 (for the last 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
- ISPAs related to communication
- 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 ISPA's for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment
- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained)
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans)
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.

- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.
- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

APPENDIX B - List of Acronyms Used in This Report

<u>Acronym</u>	<u>Meaning</u>
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
BNP	B-type natriuretic peptide
CHF	Congestive Heart Failure
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin
HDL	High-density Lipoprotein
H. pylori	Helicobacter pylori
HRC	Human Rights Committee
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
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PEG-tube	Percutaneous endoscopic gastrostomy tube

PEMA	Psychiatric Emergency Medication Administration
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
TIVA	Total Intravenous Anesthesia
UTI	Urinary Tract Infection