United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: July 11-15, 2016

Date of Report: September 26, 2016

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Table of Contents

Background 3
Methodology 4
Organization of Report 5
Executive Summary 5

Status of Compliance with Settlement Agreement
- Domain 1 6
- Domain 2 23
- Domain 3 60
- Domain 4 105
- Domain 5 114

Appendices
- A. Interviews and Documents Reviewed 124
- B. List of Acronyms 132

Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a. **Domains:** Each of the five domains heads a section of the report.
b. **Outcomes and indicators:** The outcomes and indicators are listed along with the Monitoring Teams' scoring of each indicator.
c. **Summary:** The Monitors have provided a summary of the facility's performance on the indicators in the outcome, as well as a determination of whether each indicator will move to the category of requiring less oversight or remain in active monitoring.
d. **Comments:** The Monitors have provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. **Individual numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.
f. **Numbering of outcomes and indicators:** The outcomes and indicators under each of the domains are numbered, however, the numbering is not in sequence. Instead, the numbering corresponds to that used in the Monitors' audit tools, which include outcomes, indicators, data sources, and interpretive guidelines/procedures (described above). The Monitors have chosen to number the items in the report in this manner in order to assist the parties in matching the items in this report to the items in those documents. At a later time, a different numbering system may be put into place.

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at El Paso SSLC for their openness and responsiveness to the many requests made and the extra activities of the Monitoring Teams during the onsite review. The Facility Director supported the work of the Monitoring Teams, and was available and responsive to all questions and concerns. Many other staff were involved in the production of documents and graciously worked with the Monitoring Teams while they were onsite, and their time and efforts are much appreciated.

Status of Compliance with the Settlement Agreement

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

This domain currently contains 24 outcomes and 66 underlying indicators in the areas of restraint management, abuse neglect and incident management, pretreatment sedation/chemical restraint, mortality review, and quality assurance. Thirteen of these, all in incident management, had sustained high performance scores and will be moved to the category of requiring less oversight.

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

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

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

Restraint

Overall, the use of crisis intervention restraint had decreased over the course of the nine-month period, however, the overall rates of usage of crisis intervention restraint remained high. The facility reported that it was going to re-start the restraint reduction committee. This was a good to hear. The frequency of crisis intervention restraint at El Paso SSLC requires the attention of facility management and this type of specialized focused committee. Also, there was a high frequency of injuries during implementation of crisis intervention physical restraint (130). Although all were deemed to be non-serious, this should be examined by the facility and the restraint reduction committee to ensure that restraints are implemented correctly and safely.

The restraint records nursing staff completed often contained conflicting and/or missing information related to the individual's restraint, and restraint-related injuries. As discussed with the Chief Nurse Executive (CNE) and Nursing Operations Office (NOO), the Monitoring Team recommends that nursing staff be re-trained related to restraints, and the standards of care for related documentation.

Abuse, Neglect, and Incident Management

The facility's incident management department followed policy, conducted thorough investigations, maintained proper documentation, and ensured that follow-up was completed. Further, the Incident Management Coordinator and his staff worked

well with the many different departments and staff at the facility. This had been the case at the facility for a number of years. As a result, 13 of the 23 indicators regarding this area were deemed to move to the category of requiring lesser oversight due to the high levels of performance demonstrated at this review and the past two reviews. With sustained performance, some of the other indicators may also move to this category after the next review. The primary area for focus is regarding facility-wide action plans and their implementation and follow-up.

Other

It was good to see that the Center completed clinically significant DUEs and followed-up to closure on recommendations.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.											
Summary: The use of crisis intervention restraint at El Paso SSLC decreased over the past nine months, but remained overall at a high level, especially when compared to other SSLCs. Facility actions, such as re-starting the restraint review committee were planned, but had been absent for many months. Due to the high number of occurrences of crisis intervention restraint, the frequency of injuries during restraint (though all deemed non-serious), and the absence of facility management and review, these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	67% 8/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by state office and from the facility for the past nine months (September 2015 through May 2016) were reviewed. Overall, the use of crisis intervention restraint had decreased over the course of the nine-month period, however, the overall rates of usage of crisis intervention restraint remained high. This was due, in large part, to the number of crisis intervention physical restraints for Individual #13. Over the nine months, more than 200 occurrences of crisis intervention restraint occurred with him. The facility had, by far, the highest usage of crisis intervention restraint across all SSLCs (adjusted for census). The Monitoring Team also looked at the frequency of the use of crisis intervention restraint not including Individual #13. These data also showed a decreasing trend across the nine months, but even with Individual #13's data removed, these data showed El Paso SSLC to be the third highest in the state.

The facility reported that it was going to re-start the restraint reduction committee. The frequency of crisis intervention restraint at El Paso SSLC requires the attention of facility management and this type of specialized focused committee.

The occurrences of crisis intervention physical restraints paralleled that of the overall use of crisis intervention restraint because most crisis intervention restraints at El Paso SSLC were physical restraints. The average duration of a crisis intervention physical restraint was low, lower than at the time of the last review, and, moreover, was the second lowest in the state, at approximately two minutes. The use of crisis intervention chemical restraints was low, and the use of crisis intervention mechanical restraints was zero.

Minor injuries occurred during many restraints. All were deemed non-serious. Examples were abrasions and the re-opening of scabs. Even so, the high frequency of these types of injuries should be examined by the facility and the restraint reduction committee. There were 130 such injuries during the nine-month period (43 not including Individual #13). Also, the number of individuals for whom crisis intervention restraint was used was not decreasing. It was good to see that no individuals used protective mechanical restraint for self-injurious behavior (PMR-SIB).

The use of chemical and non-chemical restraint for medical and dental procedures was low throughout the nine-month period.

Thus, state and facility data showed low usage and/or decreases in eight of these 12 facility-wide measures (i.e., use of chemical and mechanical crisis intervention restraint, duration of physical crisis intervention restraints, use of protective mechanical restraint, use of chemical and non-chemical restraints for medical and dental procedures).

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. Four received crisis intervention physical restraints (Individual #13, Individual #142, Individual #26, Individual #166), and one received crisis intervention chemical restraint (Individual #26). Data from state office and from the facility showed a decreasing trend in frequency or very low occurrences over the past nine months for three (Individual #13, Individual #142, Individual #26, Individual #166), however, Individual #26 had an increasing number of crisis intervention physical restraints over the six week period between the time of the end of the graphed data and the Monitoring Team's onsite review. Although Individual #13 had the highest frequency of occurrence of crisis intervention physical restraint ever seen at an SSLC since Settlement Agreement monitoring began, it had greatly decreased over the past three months. The other five individuals reviewed by the Monitoring Team did not have any occurrences of crisis intervention restraint during this period.

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

Summary: Overall, El Paso SSLC implemented restraint according to most of the criteria in this outcome. For instance, four of the indicators have had high scores for multiple reviews (3, 5, 6, and 8). But given the high rates of occurrence of restraint and the high number of injuries (albeit all deemed non-serious), these indicators will remain the category of active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	26	166					
3	There was no evidence of prone restraint used.	100%	2/2	2/2	2/2	2/2					

		8/8									
4	The restraint was a method approved in facility policy.	100% 8/8	2/2	2/2	2/2	2/2					
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 8/8	2/2	2/2	2/2	2/2					
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 7/7	2/2	2/2	1/1	2/2					
7	There was no injury to the individual as a result of implementation of the restraint.	63% 5/8	2/2	2/2	1/2	0/2					
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 8/8	2/2	2/2	2/2	2/2					
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	67% 2/3	Not rated	1/1	1/2	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.	100% 8/8	2/2	2/2	2/2	2/2					
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	25% 2/8	0/2	0/2	0/2	2/2					

Comments:
The Monitoring Team chose to review eight restraint incidents that occurred for four different individuals (Individual #13, Individual #142, Individual #26, Individual #166). Of these, seven were crisis intervention physical restraints, and one was a crisis intervention chemical restraint. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

7. An injury was noted for Individual #26 12/29/15 1:15 pm. This was deemed non-serious. For Individual #166 2/29/16 9:13 pm, there was no information on the restraint checklist to show nurse assessment; a handwritten note explained that the nurse was not notified of the restraint. For Individual #166 3/21/16 1:10 pm, the restraint checklist says "unknown" to the query regarding injury. It would seem post restraint review should have been able to determine this.

9. Because criterion for indicator #2 was met for two of the four individuals, this indicator was not scored for them. For the other two, criteria were met for three of their restraints. For one restraint, problems with implementation of behavioral programming were found (Individual #26 4/14/16 1:06 pm). Although Individual #166 met criterion for indicator #2, recommendations for counseling were not implemented for him.

11. The restraint consideration section of the ISP IRRFs was not correctly completed for Individual #13, Individual #142, or Individual #26.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.													
Summary: Staff correctly answered questions from the Monitoring Team. Maintaining performance at criterion at the next review will likely result in this indicator moving to the category of requiring less oversight.			Individuals:										
#	Indicator	Overall Score	13	142	26	166							
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 3/3	1/1	1/1	1/1	Not rated							
Comments:													

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.													
Summary: These indicators will remain in active monitoring.			Individuals:										
#	Indicator	Overall Score	13	142	26	166							
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	88% 7/8	2/2	2/2	2/2	1/2							
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A							
Comments: 13. For Individual #166 2/29/16 9:13 pm, the restraint checklist shows that a nurse assessment was not conducted.													

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.	
Summary: Overall, the restraint records nursing staff completed often contained conflicting and/or missing information related to the individual's restraint. While on site with the Chief Nurse Executive (CNE) and Nursing Operations Office (NOO) present, the Monitoring Team reviewed several of the records that were problematic. The Monitoring Team strongly recommended that nursing staff be re-trained related to restraints, and the standards of care for related documentation. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	13	142	26	166					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	25% 2/8	1/2	1/2	0/2	0/2					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	25% 2/8	1/2	1/2	0/2	0/2					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	25% 2/8	1/2	1/2	0/2	0/2					

Comments: The crisis intervention restraints reviewed included those for: Individual #13 on 2/15/16 at 2:56 p.m., and 4/7/16 at 3:44 p.m.; Individual #142 on 1/18/16 at 7:51 p.m., and 5/3/16 at 8:31 p.m.; Individual #26 on 12/29/15 at 1:15 p.m., and 4/14/16 at 1:06 p.m. (chemical); and Individual #166 on 2/29/16 at 9:13 p.m., and 3/21/16 at 1:10 p.m.

a. For seven of the eight restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint. The exception was for Individual #166 on 2/29/16 at 9:13 p.m.

For two of the eight restraints (i.e., Individual #13 on 2/15/16 at 2:56 p.m., and Individual #142 on 1/18/16 at 7:51 p.m.), nursing staff monitored and documented vital signs, and documented mental status. For other restraints, problems varied, but some of the common problems included omissions for respirations, and/or pulse oximetry, as well as mental status descriptions that were insufficient (e.g., "awake and alert").

b. and c. Documentation that met these criteria was found for the following restraints: Individual #13 on 2/15/16 at 2:56 p.m., and Individual #142 on 5/3/16 at 8:31 p.m. The following provide examples of concerns noted with regard to the remaining restraints:

- For Individual #13 on 4/7/16 at 3:44 p.m., the documentation contained conflicting information. For example, the nurse documented vital signs and mental status for 2:15 p.m. (i.e., an hour and a half before the restraint). On the Restraint Checklist, both the "yes" and "no" boxes for injury were checked, and the injury report completed box was checked "yes." The Face-to-Face Assessment and Debriefing form indicated: "yes" for "nurse checked injury." However, the injury report dated 4/7/16 at 3:44 p.m. stated: "no new injuries at this time." No nursing IPNs were found for the associated date and time.
- For Individual #142 on 1/18/16 at 7:51 p.m., the Restraint Checklist indicated that an injury report was completed. The Face-to-Face Assessment and Debriefing form indicated: "yes" for "nurse checked injury," and "injury report started." However, no injury report was found for the specified time.
- For Individual #26 on 12/29/15 at 1:15 p.m., the Restraint Checklist indicated that an injury report was completed. The Face-to-Face Assessment and Debriefing form indicated: "yes" for "nurse checked injury," and "injury report started." However, the injury report submitted did not correspond with the restraint date and time, and an IPN for the specified time was not found.
- For Individual #26's chemical restraint on 4/14/16 at 1:06 p.m., he received Thorazine, for which a potential side effect is orthostatic hypotension. However, no documentation was found to show that nursing staff monitored him for this potential side effect. During the onsite visit, the Monitoring Team reviewed this concern with the CNE and NOO.
- For the restraint of Individual #166 on 2/29/16 at 9:13 p.m., the record included an explanation that stated in part: "the nurse reported he was not informed of the restraint therefore the nursing assessment of the restraint checklist was not completed,

and a PCP order was not obtained." However, the Restraint and Debriefing Form boxes were checked for: Nurse checked injury, and Injury report started (if injury). There was no IPN regarding the restraint, and no injury report(s). For his restraint on 3/21/16 at 1:10 p.m., an injury report was completed that documented injuries, but the Facility's response to the document request indicated: "No IPN on file for 3/21/16 @ 1:10 p.m."

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: With one exception, high performance was maintained. But given the high rates of occurrence and high rates of injury (non-serious), this indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	13	142	26	166						
15	Restraint was documented in compliance with Appendix A.	88% 7/8	1/2	2/2	2/2	2/2						
Comments: 15. Criteria were met for all restraints for all sub-indicators, except Individual #13 2/15/16 2:56 pm restraint was for 18 minutes without documentation at the 15-minute point, as required.												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: Reviews of restraint occurred and recommendations were often made. They were not, however, always implemented. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	13	142	26	166						
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 8/8	2/2	2/2	2/2	2/2						
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	50% 2/4	N/A	1/1	1/2	0/1						
Comments: 16. There were multiple ISPAs addressing behaviors that contributed to the need for restraint, including recommended actions. 17. For Individual #26 4/14/16 1:06 pm, ISPA to review restraints noted that the PBSP was not being followed and that there was a plan to retrain staff. This was also noted at an ISPA in March 2016, making it un clear as to whether this issue was addressed. For Individual #166 2/29/16 9:13 pm, counseling was never implemented.												

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner.	
Summary: Psychiatrist involvement in crisis intervention chemical restraint	

improved from the last review. Psychiatrist follow-up and documentation of that follow-up is an area for focused attention. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	74								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								
49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1								

Comments:
47-49. These indicators applied to a chemical restraint for Individual #74. Criteria were met with the exception of a psychiatric clinic follow-up. Individual #74 was seen in psychiatry clinic five days after the chemical restraint episode, and there was no documentation regarding this restraint.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: Criteria were met for all investigations. This showed excellent progress compared to previous reviews. It is possible that with maintained performance, this indicator may move to requiring less oversight after the next onsite review. For now, it will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	26	45	166			
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			

Comments:
The Monitoring Team reviewed 12 investigations that occurred for six individuals. Of these 12 investigations, nine were DFPS investigations of abuse-neglect allegations (one confirmed, six unconfirmed, one inconclusive, one administrative referral back to the facility). The other three were for facility investigations of a sexual-related incident, an unauthorized departure from the facility, and the purchase of a weapon (BB gun). The individuals included in the incident management section of the report were chosen because they were involved in an unusual event in the nine months being reviewed, enabling the Monitoring Team to review any protections that were in place, as well as the process by which the SSLC investigated and took corrective actions. Additionally, the incidents reviewed were chosen by their type and outcome in order for the Monitoring Team to evaluate the response to a variety of incidents.

- Individual #13, UIR 16-068, DFPS 44166122, unconfirmed physical abuse allegation, 12/28/15

- Individual #142, UIR 16-102, DFPS 44235163, inconclusive verbal abuse allegation, 2/21/16
- Individual #142, UIR 16-139, DFPS 44318843, unconfirmed verbal abuse allegation, 4/22/16
- Individual #142, UIR 16-125, unauthorized departure, 3/31/16
- Individual #142, UIR 16-091, sexual incident, 2/6/16
- Individual #171, UIR 16-058, DFPS 44126415, unconfirmed physical abuse allegation, 11/21/15
- Individual #26, UIR 16-080, DFPS 44190309, unconfirmed physical abuse allegation, 1/18/16
- Individual #26, UIR 16-101, DFPS 44234221, unconfirmed verbal abuse allegation, 2/19/16
- Individual #45, UIR 16-088, DFPS 44208383, admin. referral neglect allegation, 1/29/16
- Individual #166, UIR 16-119 and UIR 16-120, DFPS 44275544, confirmed and unconfirmed neglect allegation, 3/21/16
- Individual #166, UIR 16-137, DFPS 44310692, inconclusive verbal abuse allegation, 4/18/16
- Individual #166, UIR 16-117, purchase of weapon: BB gun, 3/20/16

1. For all 12 investigations, the Monitoring Team looks to see if protections were in place prior to the incident occurring. This includes (a) the occurrence of staff criminal background checks and signing of duty to report forms, (b) facility and IDT review of trends of prior incidents and related occurrences, and the (c) development, implementation, and (d) revision of supports. To assist the Monitoring Team in scoring this indicator, the facility Incident Management Coordinator and other facility staff met with the Monitoring Team onsite at the facility to review these cases as well as all of the indicators regarding incident management.

All 12 of the investigations met the criteria for this indicator, including reviewing and acting upon previous occurrences and trends as typically evidenced in the ISP, PBSP, and/or ISPAs (or the incident did not involve any prior occurrences or trends). This was excellent progress and improvement for the facility and its incident management department. This accomplishment demonstrated the maturing of the El Paso SSLC incident management program, an area that the IMC, IMRT, and facility worked on steadily for many years. The IMRT continued to review all restraints, incidents, and injuries. It looked for follow-up. The Monitoring Team observed the IMRT meetings throughout the onsite week.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.												
Summary: Most allegations and injuries were reported appropriately. With sustained performance, after the next review, this indicator is likely to move into the category of less oversight. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	13	142	171	26	45	166				
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	1/1	4/4	0/1	2/2	1/1	3/3				

Comments:
2. The Monitoring Team rated 11 of the investigations as being reported correctly. The other one was rated as being reported late or incorrectly reported. All were discussed with the facility Incident Management Coordinator while onsite. This discussion, along with additional information provided to the Monitoring Team, informed the scoring of this indicator.

Those not meeting criterion are described below. When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

- Individual #171 UIR 16-058: The serious injury was documented on the injury report on 11/21/15 at 6:40 am and reported to the facility director at 7:51 am (beyond the one hour requirement). The UIR (on page 5) showed that it was reported to DFPS as alleged neglect/abuse at 11:19 am. This injury should have been reported to DFPS as an allegation immediately, but was not. The UIR narrative (on page 7) also showed it was reported at 1:00 pm (with no alleged perpetrator) and again at 8:20 pm (with the alleged perpetrator noted).

Outcome 3- Individuals receive support from staff who are knowledgeable about abuse, neglect, exploitation, and serious injury reporting; receive education about ANE and serious injury reporting; and do not experience retaliation for any ANE and serious injury reporting.

Summary: El Paso SSLC showed 100% performance on indicators 3 and 5 during this review and the last two reviews. Indicator 4 showed 100% at this review and the last review. Given this sustained performance, these three indicators will move to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	13	142	171	26	45	166			
3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	100% 3/3	Not rated	Not rated	1/1	Not rated	1/1	1/1			
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
5	If the individual, any staff member, family member, or visitor was subject to or expressed concerns regarding retaliation, the facility took appropriate administrative action.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			

Comments:

3. Because indicator #1 was met for three of the individuals, this indicator was not scored for them. The indicator was scored for the other three individuals and criteria were met.

4. Criteria for all four aspects of indicator 4 were met.

5. There were no occurrences of expressions of concerns of retaliation.

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.

Summary: El Paso SSLC showed 100% performance on this indicator during this review and the last review, as well as improvement of already high scores from January 2015. Given this sustained performance, this indicator will move to the

category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	13	142	171	26	45	166			
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			
Comments:											

Outcome 5– Staff cooperate with investigations.											
Summary: El Paso SSLC showed 100% performance on this indicator during this review and the last review, as well as improvement of already high scores from January 2015. Given this sustained performance, this indicator will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	13	142	171	26	45	166			
7	Facility staff cooperated with the investigation.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			
Comments:											

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.											
Summary: El Paso SSLC showed 100% performance on these indicators during this review and the last review (with one exception: indicator 10 was 92% in October 2015), as well as improvement from already high scores in January 2015. Given this sustained and improved performance, these three indicators will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	13	142	171	26	45	166			
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was utilized.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			
10	The analysis of the evidence was sufficient to support the findings and conclusion, and contradictory evidence was reconciled (i.e., evidence that was contraindicated by other evidence was explained)	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3			
Comments:											

Outcome 7– Investigations are conducted and reviewed as required.												
Summary: El Paso SSLC showed 100% performance on these indicators during this review and the last two reviews (with one exception: indicator 13 was 91% in January 2015). Given this sustained performance, these three indicators will move to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	13	142	171	26	45	166				
11	Commenced within 24 hours of being reported.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3				
12	Completed within 10 calendar days of when the incident was reported, including sign-off by the supervisor (unless a written extension documenting extraordinary circumstances was approved in writing).	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3				
13	There was evidence that the supervisor had conducted a review of the investigation report to determine whether or not (1) the investigation was thorough and complete and (2) the report was accurate, complete, and coherent.	100% 12/12	1/1	4/4	1/1	2/2	1/1	3/3				
Comments:												

Outcome 8- Individuals records are audited to determine if all injuries, incidents, and allegations are identified and reported for investigation; and non-serious injury investigations provide sufficient information to determine if an allegation should be reported.												
Summary: El Paso SSLC showed 100% performance on these indicators during this review and the last review. Given this sustained performance, these two indicators will move to the category of requiring less oversight.			Individuals:									
#	Indicator	Overall Score	13	142	171	26	45	166				
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1				
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1				
Comments:												

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.											
Summary: El Paso SSLC showed 100% performance on these indicators during this review and at the previous review for indicators 16 and 17. All three indicators improved from the January 2015 review. These indicators will remain in active monitoring; with sustained performance, they will likely move to the category of requiring less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	13	142	171	26	45	166			
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 11/11	1/1	4/4	1/1	1/1	1/1	3/3			
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 7/7	1/1	3/3	N/A	1/1	1/1	1/1			
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 8/8	1/1	4/4	1/1	N/A	N/A	2/2			
Comments:											

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.											
Summary: This outcome consists of facility indicators. There was improvement from the last review, but criteria not met for all five indicators. These five indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score									
19	For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending.	Yes									
20	Over the past two quarters, the facility's trend analyses contained the required content.	Yes									
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	Yes									
22	There was documentation to show that the expected outcome of the action plan had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified.	No									
23	Action plans were appropriately developed, implemented, and	No									

	tracked to completion.										

Comments:
19-23. Improvement was noted since the last review, especially regarding indicator 21. Further efforts remained necessary to determine whether action plans were implemented, and if they were effective in improving organizational performance.

Pre-Treatment Sedation/Chemical Restraint

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
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. For the six months prior to the review, none of the individuals that the Monitoring Team responsible for physical health reviewed used pre-treatment sedation or TIVA for dental care.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									

Comments: Based on documentation the Facility submitted, in the six months prior to the onsite review, none of the individuals the Monitoring Team responsible for physical health reviewed had medical pre-treatment sedation.

Outcome 1 - Individuals' need for pretreatment chemical restraint (PTCR) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTCR.											
Summary: IDTs were discussing some aspects of PTCR for some individuals. In some cases, treatments or strategies were discussed and/or created, but in no cases were plans or strategies implemented. All of these indicators will continue to receive active monitoring.			Individuals:								
#	Indicator	Overall Score	74	114	83						

1	IDT identifies the need for PTCR and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	67% 2/3	1/1	0/1	1/1						
2	If PTCR was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTCR, or (b) determined that any actions to reduce the use of PTCR would be counter-therapeutic for the individual.	67% 2/3	0/1	1/1	1/1						
3	If treatments or strategies were developed to minimize or eliminate the need for PTCR, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTCR, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/2	N/A	0/1	0/1						
4	Action plans were implemented.	0% 0/2	N/A	0/1	0/1						
5	If implemented, progress was monitored.	N/A	N/A	N/A	N/A						
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A	N/A	N/A	N/A						

Comments:
1-6. This outcome and its indicators applied to Individual #74, Individual #114, and Individual #83. Individual #114 and Individual #83 received general anesthesia for dental work in the last six months. Individual #74 received sedation for a CT scan on 3/4/16.

1. There was documentation that the IDT identified the need for PTCR and supports needed for Individual #74 and Individual #83. Individual #114's ISP indicated he required sedation for dental work because he refused to allow dental exams. The monthly report indicated that Individual #114 had a plan to address his dental refusals, however, PTCR usage and effectiveness during the past 12 months and the risks and benefits of the PTCR were not available.

2. No plan to reduce the usage of PTCR or documentation that actions to reduce the use of the procedure would be counter-productive was available for Individual #74.

3. Neither Individual #114 nor Individual #83's treatments to reduce the use of PTCR were found in their ISPs.

4. There was no evidence that Individual #114 or Individual #83's action plans were implemented.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: The Monitoring Team will continue to assess these indicators.			Individuals:								
#	Indicator	Overall Score									
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	N/A									
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	N/A									
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	N/A									
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	N/A									
e.	Recommendations are followed through to closure.	N/A									
Comments: Since the last review, one individual died. On 5/31/16, Individual #72 died. At the time of the onsite review, the Center had not completed the clinical and administrative reviews. The autopsy report and cause of death were still pending.											

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	ADRs are reported immediately.	N/A									
b.	Clinical follow-up action is completed, as necessary, with the individual.	N/A									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	N/A									

d.	Reportable ADRs are sent to MedWatch.	N/A									
Comments: a. through d. Facility staff had not identified and/or reported adverse drug reactions for any of the individuals reviewed.											

Outcome 4 – The Facility completes Drug Utilization Evaluations (DUEs) on a regular basis based on the specific needs of the Facility, targeting high-use and high-risk medications.		
Summary: Given that during the last review period and during this review, the Center completed clinically significant DUEs and followed up to closure on recommendations, if this performance is sustained during the next review, this Outcome likely will move to the category of requiring less oversight.		
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 3/3
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 3/3

Comments: a. and b. In the six months prior to the review, El Paso SSLC completed three DUEs, including:

- In May 2016, a DUE on sublingual Atropine;
- In April 2016, a DUE on Onychomycosis; and
- In December 2015, a DUE on Serotonin Syndrome Causing Medication.

Domain #2: Using its policies, training, and quality assurance systems to establish and maintain compliance, the State will provide individuals in the Target Population with service plans that are developed through an integrated individual support planning process that address the individual's strengths, preferences, choice of services, goals, and needs for protections, services, and supports.

This domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Seven of these, in psychiatry, medical, nursing, and communication, had sustained high performance scores and will be moved the category of requiring less oversight.

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

Individualized Support Plans

ISPs did not yet contain personal goals and action plans that met the various criteria regarding individualization and measurability.

Integrated Risk Rating Forms

For the individuals' risks reviewed, none of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

Assessments

On a positive note, for this review and the previous two reviews, nursing staff completed the comprehensive nursing assessments in a timely manner. Similarly, for this review and the previous two reviews, Medical Department staff completed the medical assessments in a timely manner. As a result, the related indicators will be placed in the category of requiring less oversight. Similarly, comprehensive psychiatric evaluations, annual psychiatry updates, behavioral assessments, functional assessments, and various skill acquisition-related assessments were present and up to date. PBSPs were current, and SAPs existed for all individuals.

Although some additional work was needed, the Center made progress with regard to the quality of medical assessments. For five of the nine individuals reviewed, the Medical Department assessed individuals' medical needs in accordance with generally accepted standards of care. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe childhood illnesses, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.

Overall, the dentist's documentation did not meet generally accepted standards. Assessments forms often included blank sections, so it was difficult at times to determine if the dentist left it blank or did not think the question was applicable. The medication section consistently pointed the reader to the medical chart, making it unclear whether or not the dentist reviewed the medications. Very often, the IRRF summary within the Annual Dental Summary was not consistent with the individual's current status. The hygiene ratings and risk ratings in the IRRF summary often differed from the hygiene ratings listed in the Annual Dental Exam (at times, the date for both was the same).

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

Overall, the PNMT assessments were not well organized with analysis and recommendations scattered throughout and not summarized. This would make it difficult for the IDTs to understand and act upon the assessment information. The PNMT had not consistently identified the etiology/cause of the problem, and the steps necessary to mitigate risk. Similarly, the analysis of the effectiveness of current supports often was not clear, making it unclear what, if anything, needed to change. The PNMT often did not clearly define individualized clinical indicators to assist IDTs in identifying when the individual was healthy and/or when deterioration was potentially occurring. In addition, it often appeared that various disciplines had completed their own assessments, but had not integrated their findings with other team members' findings and recommendations. At times, recommendations were not well justified or clearly explained. The Center should focus on improving the quality of these assessments.

Some progress was seen with regard to the quality as well as timeliness of OT/PT assessments.

Psychiatry evaluations were, for the most part, completed, but most were missing adequate bio-psycho-social formulations. Behavioral health service's functional assessments needed improvement in ensuring that direct assessment includes all target behaviors (or a rationale why target behaviors were not included), identification of relevant antecedents and/or clear summary statements that were based on the hypothesized antecedent and consequent conditions that affected the target behaviors.

Integrated Health Care Plans

Overall, the IHCPs of the individuals reviewed were not sufficient to meet their needs. Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs, as well as nursing and physical and nutritional support interventions.

Positive Behavior Support Plans
Half of the PBSPs met criteria for content. The others needed improvement in the replacement behaviors chosen for implementation, and ensuring that interventions are related to the assessed functions of the target behaviors.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: El Paso SSLC had recently completed training in the new ISP process. ISPs did not yet set goals that were individualized and met the criteria for this outcome. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	74	26	45	70	10				
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	0/6	1/6	0/6	3/6	3/6				
2	The personal goals are measurable.	0% 0/6	0/6	0/6	1/6	0/6	3/6	2/6				
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6				

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #74, Individual #45, Individual #26, Individual #142, Individual #70, Individual #10). 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 El Paso SSLC campus. The ISPs were developed between 8/6/15 and 2/9/16. Goals written in the latest ISPs were better examples of individualized, measurable goals based on preferences, strengths, and needs.

1. None of the individuals had a full array of individualized goals. Examples of goals that were not individualized based on preferences, strengths, and needs included:

- Individual #74's living option goal to become more medically and behaviorally stable and his relationship goal to play table activities.
- Individual #45's living option goal to gain/improve her community exposure.
- Individual #142's leisure goal to participate in leisure activities of her choice.
- Individual #70's goal for work/day that stated he would continue to attend groups.
- Individual #10's employment goal to attend workshop daily.

Even though more individualized, there was still little evidence that goals were written to give individuals opportunities for greater exposure to new experiences or to develop new skills that might lead to a broader range of preferences. For example, relationship goals typically were written to increase contact with family or continue outings with peers. There were no goals written to encourage the

development of new relationships, particularly in the community.

Examples of individualized, measurable goals that were based on preferences included:

- Individual #142's goal for greater independence to learn to wash her clothes.
- Individual #70's goal for greater independence to open the door when going to groups.

The Monitoring Team acknowledges that the development of personal goals that will meet criteria is a work in progress at all facilities. More guidance is expected from state office. Moreover, the QIDP coordinator will be very important in supporting teams to make goals that meet criterion for compliance. To do so, she will need to provide a lot of feedback to the QIDPs and to other team members.

2. Some of the goals for individuals were written in measurable terms. Most personal goals, however, did not include a clear indicator that could be used to determine when the goals had been met.

Personal goals should be aspirational statements of outcomes. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

3. Review of data implementation sheets, ISP preparation documentation, and QIDP monthly reviews indicated that consistent data were not collected for most ISP action plans. Monthly reviews of services and supports noted gaps in implementation and data collection for all of the individuals. In some cases, it was noted that action plans were never fully implemented during the ISP year. As noted, most personal goals and action plans were not measurable, therefore, there was no basis for assessing whether reliable and valid data were available.

For the goals that did meet criterion, there were not reliable and valid data on implementation of the plans to address the goals. Review of data implementation sheets, ISP preparation documentation, and QIDP monthly reviews indicated that consistent data were not collected for most ISP action plans.

The Monitoring Team observed Individual #26 and Individual #45's annual ISP meetings. Individual #26's IDT considered individualized goals that would offer him opportunities to learn new skills based on his stated preferences, however, his LAR was reluctant to implement significant changes in his current programming. Individual #45's IDT made few changes in her current ISP and failed to develop a plan that would provide opportunities to learn new skills and increase her independence.

Outcome 3: There were individualized measurable goals/objectives/treatment strategies to address identified needs and achieve personal outcomes.	
Summary: When considering the full set of ISP action plans, the various criteria included in the set of indicators in this outcome were not met, but in a handful of cases. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	142	74	26	45	70	10			
8	ISP action plans support the individual's personal goals.	0% 0/6	0/6	0/6	1/6	0/6	1/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	17% 1/6	1/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	0% 0/5	N/A	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	1/6	0/6	2/6	0/6	2/6	0/6			

Comments:
8. Most personal goals did not meet ISP indicator 1 in the ISPs as indicated above. Individual #26's leisure goal met the criteria in indicator 1, and his action plans did support his goal. For Individual #70, his goal to address greater independence met criteria for indicator 1 and he had action plans to support the achievement of this goal. But on the other hand, while his leisure and relationship goals were individualized and based on his preferences, the team did not develop action plans that were likely to lead to the accomplishment of those goals.

9. Preferences and opportunities for choice were addressed in one of six ISPs. Individual #10's ISP included goals based on his

preferences for going to church, making money, and Mexican food. Individuals had limited opportunities to learn new skills based on identified preferences. Preferences for specific activities and skill building opportunities were not defined. None of the ISPs identified what work skills the individual might need to learn to succeed at employment other than behavioral goals that might relate to employment.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for the individuals. At the annual ISP meeting for Individual #26, observed by the Monitoring Team, the IDT supported Individual #26's participation in the ISP development process, including his expression of various preferences for activities, learning new skills, doing things in the community, and ultimately transitioning to community living. This was very positive and was in line with much of what the state's new ISP process is all about. Individual #26's guardian, however, opposed most of these actions, that is, she did not support Individual #26 or his team to help him make decisions regarding his immediate future, learn how to make better decisions, learn new skills, and so forth.

11. Action plans for one of six individuals supported her enhanced independence. Individual #45 had action plans to place her cup at the table and put her clothes in the hamper. Individual #74, Individual #26, Individual #142, and Individual #70 had greater independence goals that included action plans for skills that the FSA indicated they were already able to complete. Individual #10's greater independence goal appeared to be a compliance issue rather than a goal to learn new skills.

12. ISP action plans did not adequately integrate strategies to reduce risks. For example,

- Individual #45's ISP failed to integrate strategies to reduce risk related to her recent hospitalization and diagnosis for cancer.
- Individual #26's ISP indicated that a recommendation to develop a new crisis intervention plan related to restraints was not implemented.
- Recommended mobility supports and strategies were not integrated into Individual #70's action plans.

See additional comments related to At-Risk outcomes.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were not well integrated. Examples included:

- Individual #74's SAPs included generic statements regarding recommendations from his SLP. Instructions specific to the skill being taught were not included in the teaching and support strategies.
- Behavioral support strategies were not considered when addressing Individual #45's need for general anesthesia during dental treatment. The team acknowledged that Individual #45 was at high risk when receiving general anesthesia. The IDT needs to work with the behavioral health specialist to develop a plan to minimize her risk.
- For Individual #26, habilitation and behavior support recommendations were not integrated into teaching and support strategies.
- Individual #70's action plans related to walking and opening doors did not integrate specific recommendations and support strategies from habilitation therapies.

14. Meaningful and substantial community integration was largely absent from the ISPs. There were no specific plans for community

participation that would have promoted any meaningful integration for any individual. The facility reported that all individuals routinely attended day programming at community recreation centers. This had been occurring for a number of years and was a positive aspect of the program at El Paso SSLC. Participation, however, was not addressed in the ISP (e.g., with goals and/or action plans) or documented in enough narrative detail to be able to determine if participation resulted in opportunities for true integration or functional skill building.

15. One of six IDTs (Individual #10) considered opportunities for day programming in the most integrated setting, consistent with the individual's preferences and support needs. For the most part, individual preferences were not assessed and programming was not based on known preferences or opportunities to develop new skills. Vocational goals tended to focus on compliance with attendance rather than developing skills that might result in work that the individual found interesting.

- Individual #74's IDT deferred consideration of employment without considering jobs he might be interested in, even though he is only 50 years old and had no documented work history.
- Individual #45's preferences related to day programming were very limited and the team had not considered further assessment to find new activities that might be more meaningful.
- Individual #142's stated preferences for employment related to laundry, cleaning tables, housekeeping, and kitchen work were not used to develop her employment goal.
- Individual #70's IDT did not identify individualized day or employment outcomes based on his preferences.
- Individual #26 was not offered individualized employment opportunities based on his preferences. His IDT did a better job of identifying his employment goals, however, at the annual ISP meeting observed by the Monitoring Team during the monitoring visit.
- Individual #10's ISP did document his possible interest in community employment, (however, citizenship was noted to be a barrier).

16. Opportunities for functional engagement with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs were detailed in one of six ISPs (Individual #10). Functional skill building opportunities were limited for all individuals. Observations by the Monitoring Team did not support that ISPs were regularly implemented and that individuals were engaged in functional activity. Although Individual #26 and Individual #142 were observed to be functionally engaged in work for most of the day observations, neither ISP included personal goals to support meaningful day programming based on preferences, strengths, and support needs.

17. Overall, individuals were making little progress towards outcomes, and barriers were not regularly identified and addressed in the ISP, and as noted in other sections of this report, particularly barriers related to health and participation in day programming. SAPs were often continued from the previous ISP without identifying barriers to consistent implementation.

18. 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. SAPs often did not describe the behavioral objective. IHCP goals/objectives and interventions were often not measurable. In many cases, action plans were written to measure attendance without consideration of building skills to achieve the goal, as noted above.

Outcome 4: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.												
Summary: Criterion was met for some indicators for some individuals, but overall, more work was needed to ensure that all of the activities occurred related to supporting most integrated setting practices within the ISP. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	142	74	26	45	70	10				
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1				
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A				
21	The ISP included the opinions and recommendation of the IDT's staff members.	50% 3/6	1/1	0/1	0/1	0/1	1/1	1/1				
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1				
23	The determination was based on a thorough examination of living options.	50% 3/6	1/1	0/1	1/1	0/1	0/1	1/1				
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	83% 5/6	1/1	1/1	1/1	0/1	1/1	1/1				
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A				
26	IDTs created individualized, measurable action plans to address any identified obstacles to referral or, if the individual was currently referred, to transition.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1				
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A				
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1				
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A				

Comments:
19. Three of six ISPs included a description of the individual's preference and how that was determined.

20. At the ISP meeting observed, Individual #26 stated his preferences in regards to living options.

21. Three of six ISPs included a statement regarding the overall decision of the entire IDT, exclusive of the individual and LAR. The opinions of key staff members were not documented for Individual #74. Individual #26 and Individual #45's ISPs were missing opinions from key staff members. Individual #26's ISP did not document recommendations from his PCP, psychiatrist, or behavior support staff. Individual #45's ISP did not document recommendations from nursing or psychiatry. Given her healthcare needs and concerns regarding possible onset of dementia, those opinions would have been relevant to planning.

22. Five of six ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Individual #45's ISP was incomplete for Item16.f which is the section that documents the overall decision of the team and barriers to referral.

23. Three individuals documented a fairly comprehensive examination of living options based upon their preferences, needs, and strengths. This included Individual #26, Individual #142, and Individual #10. For the remaining, the IDT did not discuss preferences in regards to living environments and how those preferences might be supported in the community.

24. Five of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #45's IDT noted that medical concerns were barriers to placement. It was not clear what supports were needed that could not be provided in the community. The IDT failed to mark medical concerns on the checklist identifying barriers.

26. None of the individuals had action plans that were individualized and measureable to address barriers to referral for community placement.

28. ISPs did not include individualized measurable plans to educate the individual or when applicable the LAR.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.											
Summary: ISPs were developed in a timely manner, but not implemented. Not all IDT members participated in the important annual meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	74	26	45	70	10			
30	The ISP was revised at least annually.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			

#	Indicator	Overall Score	142	74	26	45	70	10			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	67% 4/6	1/1	1/1	1/1	1/1	0/1	0/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
30. ISPs were developed on a timely basis.

32. A review of ISP preparation documentation, SAP data sheets, and QIDP monthly reviews did not provide evidence of timely implementation of action plans. Per those QIDP monthly reviews that were completed, all individuals had numerous action plans that were not implemented consistently.

33. Individual #70 and Individual #10's participation in their ISP development was not documented.

34. Individuals did not have an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. Examples included:

- Individual #10's PT and PCP did not participate in his annual IDT meeting despite his complex health and therapy support needs.
- At Individual #45's ISP meeting observed by the Monitoring Team, Individual #45's PCP did not participate in her ISP despite her complex medical needs and recent change in status. The IDT was to answer some questions regarding her health status that would impact supports for the upcoming year.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: Assessments that were needed were considered and identified by the IDTs. They were not, however, always obtained prior to the ISP meeting. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	74	26	45	70	10			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			

Comments:

35. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting, as documented in the ISP preparation meeting.

36. For the most part, IDTs did arrange for and obtain all needed assessments prior to the IDT meeting, however, not all assessments were submitted 10 days prior to the ISP meeting.

- For Individual #74, the IDT recommended a swim assessment, it was not completed. His behavior assessment was submitted late.
- Individual #45's habilitation, behavioral, and vocational assessments were submitted late.
- Individual #26's behavior assessment was submitted late.
- Individual #142's behavioral, psychiatric, and medical assessments were submitted late.
- Individual #10's nursing, habilitation therapy, behavioral, functional skills, nutritional, medical, and vocational assessments were submitted late according to data gathered by the QIDP.
- Individual #70's assessments were all submitted prior to the ISP meeting and timely.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: IDT and QIDP reviews were not occurring regularly, were not based on data, and did not result in actions when needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	74	26	45	70	10			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs generally met when the individual experienced some type of regression or change in status, but they rarely used data to make decisions about revising the ISP. As noted throughout this report, consistent reliable data were not available to help teams determine if supports were effective and if the individual was making progress. It was not evident that IDT members always reviewed supports and took action as needed when individuals failed to make progress on outcomes, experienced regression, or refused to participate. For all individuals, QIDPs had only recently begun completing monthly reviews of services and supports.

38. QIDPs were not monitoring action plans on a monthly basis. The QIDP monthly review process had been suspended and was not reinstated until April 2016. Consistent implementation, progress, and/or regression could not be determined due to missing data for all individuals. It was not evident that reviews resulted in action taken when ISPs were not implemented or not effective. QIDP monthly reviews were not comprehensive and did not review the status of all supports.

Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	The individual's risk rating is accurate.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The IRRF is completed within 30 days for newly-admitted individuals, updated at least annually, and within no more than five days when a change of status occurs.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas [i.e., i.e., Individual #45 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #74 – weight, and UTIs; Individual #140 – gastrointestinal problems, and seizures; Individual #81 – infections, and other: pain; Individual #71 – hypothermia, and other: elevated intraocular pressure; Individual #169 – gastrointestinal problems, and seizures; Individual #72 – respiratory compromise, and constipation/bowel obstruction; Individual #10 – respiratory compromise, and infections; and Individual #70 – respiratory compromise, and skin integrity].

a. For the individuals' risks reviewed, none of the IDTs effectively used supporting clinical data (including comparisons from year to year), used the risk guidelines when determining a risk level, and/or as appropriate, provided clinical justification for exceptions to the guidelines. As a result, it was not clear that the risk ratings were accurate.

b. For the individuals the Monitoring Team reviewed, the IDTs had not consistently updated the IRRFs at least annually with relevant information from the past year. In addition, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: The development of individualized psychiatric goals was being addressed by state office. Over the next few months, those activities should impact El Paso SSLC's psychiatric goals and move them towards meeting criteria with these indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166

4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments:
4-7. Psychiatry related goals for individuals, when present, related to the reduction of problematic behaviors, such as aggression. Individuals were lacking goals that linked the monitored behaviors to the symptoms of the psychiatric disorder and that provided measures of positive indicators related to the individual's functional status. All of the goals will need to be formulated in a manner that would make them measurable, based upon the individual's psychiatric assessment, and provide data so that the individual's status and progress can be determined. The data will allow the psychiatrist to make data driven decisions regarding the efficacy of psychotropic medications.

In some examples, psychiatry had authored goals and included these in the quarterly review document. These goals were not based on a reduction of psychiatric symptoms from a measurable baseline, nor did they indicate specific symptoms to monitor based on a diagnosis, however, it was good to see psychiatry beginning to incorporate goal development into documentation. The Monitoring Team recommends that the psychiatry department obtain guidance and feedback from state office regarding the development and documentation of psychiatry-related goals.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: CPEs were done for each individual and they were formatted correctly. This has been the case at El Paso SSLC for some time now. These two indicators will move to the category of less oversight. There remained a need for improvement in CPE content as well as the documentation required for indicators 15 and 16. These three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
12	The individual has a CPE.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
13	CPE is formatted as per Appendix B	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
14	CPE content is comprehensive.	25% 2/8	1/1	0/1	0/1	0/1	0/1	1/1	0/1	N/A	0/1

#	Indicator	Overall Score									
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.	25% 1/4	N/A	0/1	0/1	N/A	0/1	N/A	N/A	N/A	1/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	50% 4/8	0/1	0/1	0/1	1/1	0/1	1/1	1/1	N/A	1/1

Comments:
12-13. Each individual had a CPE and it was formatted as per Appendix B.

14. The Monitoring Team looks for 14 components in the CPE. Two evaluations were complete. For the six evaluations that did not include the required content, three lacked sufficient bio-psycho-social formulations. This was the most common deficiency. Three evaluations were lacking sufficient information in two elements, and three evaluations were lacking sufficient information in one element.

15. For the four individuals admitted since 1/1/14, all had psychiatric evaluations performed within 30 days of admission. Three individuals were lacking an integrated progress note from the primary care provider documenting the admission assessment within the first business day after admission.

16. There was a need for improvement with regard to the consistency of diagnoses. For example, in the case of Individual #13, psychiatry indicated a diagnosis of Antisocial Personality Disorder. This was not included in the medical documentation.

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

Summary: Psychiatric treatment documentation was updated within the past 12 months. This had been occurring at El Paso SSLC for some time and, therefore, this indicator (#17) will move to the category of requiring less oversight. The other four indicators were not at criterion and reflected the need for more psychiatry involvement in the ISP process. These will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
17	Status and treatment document was updated within past 12 months.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	1/1	N/A	N/A
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	0% 0/6	0/1	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	75% 6/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1	N/A	1/1

20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	13% 1/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. Overall, the annual evaluations did not meet criterion for these aspects: derivation of symptoms, symptoms of diagnosis, and risk versus benefit discussion. Individual #45 did not receive psychiatric services. Individual #142 and Individual #166 were new admissions.

19-20. These indicators were scored based upon the documentation provided to the Monitoring Team.

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

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

Summary: The proper use of psychiatric support plans remains an area in need of focus at the facility. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	0% 0/2	N/A	N/A	0/1	N/A	0/1	N/A	N/A	N/A	N/A

Comments:
22. Two individuals had psychiatric support plans. The plan for Individual #171 did not have the correct psychiatric diagnosis. The plan for Individual #74 was inappropriate in that the team had determined almost a year ago that he should have a behavior support plan.

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

Summary: Consent forms were completed and information was understandable. Some aspects (risk versus benefit, non-pharmacological interventions) needed more focused attention. Overall, there was improvement in this outcome and with continued improvement, it is possible that some of these indicators might move to the category of requiring less oversight after the next review. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
31	Written documentation contains reference to alternate and non-pharmacological interventions that were considered.	50% 4/8	1/1	0/1	1/1	0/1	0/1	1/1	1/1	N/A	0/1
32	HRC review was obtained prior to implementation and annually.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

Comments:
28. The facility transitioned to the revised consent form. With regard to Individual #142, the consent form for Trazodone was not provided for review.

29. The facility had made the transition to a revised version of the consent form. These consent forms included basic side effect information. In addition, the consent documents included a detailed list of medication side effect information that was provided as a separate document attached to the consent form.

30-31. The risk versus benefit discussion was not included in the consent form. Rather, they were included in the psychiatric medication treatment plan. Alternate and non-pharmacological interventions included in four examples were essentially a standardized list of items. In the other four examples, individualized alternatives were included.

32. These scores were an improvement from the last review.

Psychology/behavioral health

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

Summary: One individual did not have a PBSP in place, even though the IDT requested one many months ago, thus, even though indicator 1 had a high score, it will remain in active monitoring. When a PBSP was in place, El Paso SSLC had goals and objectives that met criteria. The lack of reliable data, however, was missing. All the indicators in this outcome will continue under active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166

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.	91% 10/11	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
4	The goals/objectives were based upon the individual's assessments.	83% 5/6	1/1	1/1	N/A	N/A	1/1	0/1	1/1	N/A	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	17% 1/6	0/1	0/1	N/A	N/A	0/1	1/1	0/1	N/A	0/1

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, 11 required a PBSP (seven individuals reviewed by the behavioral health Monitoring Team and four individuals reviewed by the physical health Monitoring Team). Ten of those 11 individuals had PBSPs. The exception was Individual #74. He did not have a PBSP at the time of the onsite review. He engaged in rates and intensity of SIB that placed him at risk and therefore warranted a PBSP. It was particularly concerning that IDT members, including those from behavioral health services, had repeatedly recommended a PBSP since August 2015. Ensuring that individuals who engage in behaviors that are dangerous to themselves or others have a PBSP should be a priority area for improvement for the El Paso SSLC behavioral health services department.

2-3. All individuals with a PBSP had measurable objectives rated to behavioral health services.

4. Five of the individuals had objectives based on assessments. Individual #114, however, did not have a functional assessment.

5. Individual #114 had interobserver agreement (IOA) and data collection timeliness assessments in the last six months that were at or above 80%, indicating that his PBSP data were reliable. Individual #166, Individual #83, Individual #26, and Individual #142 had IOA measures that were above 80%, however, they did not have data collection timeliness (DCT) measures. Individual #13 had an IOA assessment in May 2015, however, it was 0%, and he did not have any DCT measures reported. In order to ensure that target and replacement behavior data are reliable, it is critical that all individuals with a PBSP have regular IOA and data collection measures. Additionally, if the levels of DCT or IOA fall below 80%, staff should be retrained and reassessed as soon as possible. Ensuring reliability of PBSP data should be a priority area for improvement for the El Paso SSLC behavioral health services department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: Some of these indicators received good scores. With sustained performance, at a future monitoring review, some might be moved to the category of requiring less oversight. At this time, all remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	83% 5/6	1/1	1/1	N/A	N/A	1/1	0/1	1/1	N/A	1/1
12	The functional assessment is complete.	20% 1/5	1/1	0/1	N/A	N/A	0/1	N/A	0/1	N/A	0/1
Comments: 11. Individual #114 had a PBSP, however, he did not have a functional assessment. 12. Individual #13 had a complete functional assessment. Individual #142 and Individual #26's functional assessments were rated incomplete because the direct assessment did not include any target behaviors or a rationale why target behaviors were not included. Individual #166's functional assessment did not clearly identify relevant antecedents. Individual #83, Individual #26, Individual #166, and Individual #142's functional assessments did not have clear summary statements that were based on the hypothesized antecedent and consequent conditions that affected the target behaviors. Improving the quality of the functional assessments should be a priority area for improvement for the El Paso SSLC behavioral health services department.											

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Work needs to be done to improve the content of PBSPs and also in obtaining all necessary consents and approvals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 4/6	1/1	1/1	N/A	N/A	0/1	0/1	1/1	N/A	1/1
14	The PBSP was current (within the past 12 months).	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	50% 3/6	1/1	1/1	N/A	N/A	1/1	0/1	0/1	N/A	0/1
Comments: 13. Available data indicated that Individual #26 and Individual #114's PBSPs were implemented prior to their consent.											

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Individual #13, Individual #142, and Individual #26's PBSPs were rated as containing all of these components. Individual #166's PBSP was rated as incomplete because the replacement behaviors were not functional and there was no rationale provided why a functional replacement behavior was not practical or possible. Individual #114 and Individual #83's PBSP did not appear to be based on the results of the hypothesized function of their target behaviors. Improving the quality of the PBSPs should be a priority area for improvement for the El Paso SSLC behavioral health services department.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: Most, but not all, individuals who were referred for counseling received counseling. Counseling treatment plans and progress notes were not complete. These indicators will remain under active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	75% 3/4	1/1	1/1	N/A	N/A	1/1	N/A	N/A	N/A	0/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	0% 0/2	N/A	0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A
Comments: 24. Individual #13, Individual #26, Individual #142, and Individual #166 had documentation of referral for counseling by their IDTs. Individual #13 refused counseling, and there was evidence that Individual #142 and Individual #26 were receiving counseling. There was, however, no evidence that Individual #166 was receiving counseling or an explanation why he was not receiving counseling. 25. Individual #26 had a complete treatment plan, however, his progress notes did not appear to be related to his objectives. Individual #142 had progress notes, however, she did not have a counseling treatment plan.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely medical assessments (Round 9 – 78%, Round 10 – 100%, and Round 11 -100%), Indicators a. and b. will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70

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	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	Not rated (N/R)									
Comments: c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.											

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Although some additional work was needed, the Center had made progress with regard to the quality of medical assessments. Given that over the last two review periods and during this review, individuals reviewed generally had diagnoses justified by appropriate criteria (Round 9 – 89% for Indicator 2.e, Round 10 – 100% for Indicator 2.e, and Round 11 -100% for Indicator 3.b), Indicator b. will move to the category of requiring less oversight. The remaining indicator for this Outcome will be assessed once the ISPs reviewed integrate the revised periodic assessment process.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual receives quality AMA.	56% 5/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	83% 15/18	2/2	2/2	2/2	2/2	2/2	2/2	0/2	1/2	2/2
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	N/R									
Comments: a. It was positive that the annual medical assessments for five of the nine individuals assessed individuals' medical needs in accordance with generally accepted standards of care. For the remaining medical assessments, problems varied. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, and pertinent laboratory information. Moving forward, the Medical Department should focus on ensuring medical assessments, as appropriate, describe childhood illnesses, and include updated active problem lists, and plans of care for each active medical problem, when appropriate.											

The Active Problem List/Status/Plan section of the AMAs listed each medical problem. The status of the problem was often listed as "stable," rather than providing the actual assessment of the condition. Stability is a function of time. Therefore, the status of a particular condition might not be optimal or have reached the desired outcome, but might be stable if it has remained without change. For example, a hemoglobin (Hb) A1c or low-density lipoprotein (LDL) might be stable even though target values have not been achieved. It was also noted that the exact information discussed in the Active Problem List/Status/Plan section was repeated in the summary. This usually added an additional two to three pages of text that was previously stated.

b. For each of the nine individuals, the Monitoring Team reviewed two diagnoses to determine whether or not they were justified using appropriate criteria. The diagnoses for which concerns were noted were:

- Individual #72 had a diagnosis of "borderline diabetes" listed in the Active Problem List. The diagnosis should have been either diabetes mellitus or pre-diabetes. In addition, he had a diagnosis of "+PPD without tuberculosis," which should have been latent tuberculosis infection (LTBI).
- For Individual #10, the term insulin dependent diabetes mellitus was used, which is an outdated classification scheme for diabetes mellitus.

c. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	17% 3/18	1/2	0/2	0/2	0/2	0/2	1/2	0/2	1/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	N/R									

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [Individual #45 – diabetes, and osteoporosis; Individual #74 – other: hypothyroidism, and osteoporosis; Individual #140 – seizures, and constipation/bowel obstruction; Individual #81 – diabetes, and respiratory compromise/aspiration; Individual #71 – infections, and constipation/bowel obstruction; Individual #169 – osteoporosis, and gastrointestinal (GI) problems; Individual #72 – infections, and diabetes; Individual #10 – infections, and diabetes; and Individual #70 – osteoporosis, and other: hydrocephalus]. The IHCPs that sufficiently addressed the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations were: Individual #45 – diabetes, Individual #169 – GI problems, and Individual #10

– infections.

b. This indicator is new and reflects a revised process for the conduct of periodic medical reviews. It was not assessed during this review, but will be during upcoming reviews.

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely dental examinations (Round 9 – 100%, Round 10 – 100%, and Round 11 -80%) and dental summaries (Round 9 – 100%, Round 10 – 100%, and Round 11 -100%), Indicator a will move to the category of requiring less oversight. The Facility needs to focus on the quality of dental exams and summaries.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	22% 2/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual receives a comprehensive dental summary.	11% 1/9	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: It was positive that dental summaries were completed no later than 10 working days prior to the ISP meeting.

b. It was positive that Individual #74 and Individual #10 had dental exams that met criteria. It should be noted that both of these individuals were edentulous. Problems varied for the remaining dental exams reviewed. On a positive note, all of the dental exams reviewed sufficiently addressed:

- A description of the individual's cooperation;
- An oral cancer screening;
- An oral hygiene rating completed prior to treatment;

- A description of sedation use;
- A description of periodontal condition;
- Caries risk;
- Periodontal risk; and
- Specific treatment provided.

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

- Information regarding last x-ray(s) and type of x-ray, including the date;
- Periodontal charting;
- An odontogram (although the Center provided odontograms in color, they did not include a key to allow interpretation):
- A summary of the number of teeth present/missing;
- The recall frequency; and
- A treatment plan.

c. Individual #74, who was edentulous, had a dental summary that included all of the necessary components. Problems varied amongst the remaining dental summaries reviewed. Moving forward, the Facility should focus on ensuring dental summaries include the following, as applicable:

- Recommendations related to the need for desensitization or other plan;
- A summary of the number of teeth present/missing, which is important due to the fact that odontograms might be difficult for IDTs to interpret;
- Effectiveness of pre-treatment sedation;
- Identification of dental conditions (aspiration risk, etc.) that adversely affect systemic health;
- Provision of written oral hygiene instructions;
- Recommendations for the risk level for the IRRF;
- Dental care recommendations;
- A description of the treatment provided; and
- Treatment plan, including the recall frequency.

Overall, the dentist's documentation did not meet generally accepted standards. Assessments forms often included blank sections, so it was difficult at times to determine if the dentist left it blank or did not think the question was applicable. The medication section consistently pointed the reader to the medical chart, making it unclear whether or not the dentist reviewed the medications.

The Annual Dental Summaries appear to be cut and pasted from other documents. Very often, the IRRF summary within the Annual Dental Summary was not consistent with the individual's current status. The hygiene ratings and risk ratings in the IRRF summary often differed from the hygiene ratings listed in the Annual Dental Exam (at times, the date for both was the same).

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.											
Summary: Given that over the last two review periods and during this review, individuals reviewed generally had timely comprehensive nursing assessments (Round 9 – 89%, Round 10 – 67%, and Round 11 -100%), Indicators a.i. and a.ii. will move to the category of requiring less oversight. The remaining indicators require continued focus to ensure nurses complete timely quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 7/7	1/1	1/1	1/1	1/1	N/A	N/A	1/1	1/1	1/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	67% 6/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	0/1
b.	For the annual ISP, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in developing a plan responsive to the level of risk.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	If the individual has a change in status that requires a nursing assessment, a nursing assessment is completed in accordance with nursing protocols or current standards of practice.	33% 3/9	0/1	N/A	N/A	0/2	N/A	0/1	0/1	2/2	1/2

Comments: a. It was positive that for the two individuals who were newly admitted and seven remaining individuals, nursing staff completed timely comprehensive nursing reviews and physical assessments.

With regard to quarterly nursing record reviews and physical assessments:

- For Individual #70, the nursing assessment indicated the nurse "forgot" to complete a quarterly review after the individual was discharged from the hospital in March 2016, and did not finalize it until the end of June 2016.

- For Individual #72, the first quarterly review did not include a physical assessment or Braden Scale.
- For Individual #81, the first quarterly review was not dated at the signature line.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (Individual #45 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #74 – weight, and UTIs; Individual #140 – gastrointestinal problems, and seizures; Individual #81 – infections, and other: pain; Individual #71 – hypothermia, and other: elevated intraocular pressure; Individual #169 – gastrointestinal problems, and seizures; Individual #72 – respiratory compromise, and constipation/bowel obstruction; Individual #10 – respiratory compromise, and infections; and Individual #70 – respiratory compromise, and skin integrity).

None of the nursing assessments sufficiently addressed the risk areas reviewed. Overall, the annual comprehensive nursing assessments did not contain reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Common problems included a lack of or incomplete analysis of health risks, including comparison with the previous quarter or year; incomplete clinical data; and/or a lack of recommendations regarding treatment, interventions, strategies, and programs (e.g., skill acquisition programs), as appropriate, to address the chronic conditions and promote amelioration of the at-risk condition to the extent possible. In a number of instances, information in the nursing assessments was inconsistent with information found in other portions of the record (e.g., Individual #81 with regard to pain, and Individual #10 with regard to respiratory compromise, as well as infections).

Outcome 4 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.											
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Overall, the IHCPs of the individuals reviewed did not include nursing interventions sufficient to meet their needs.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: Although the Center's scores varied somewhat over the last two reviews, the scores during this review generally showed improvement with regard to timely referral of individuals to the PNMT as needed, completion of the PNMT initial review, completion of the PNMT assessment, and involvement of the necessary disciplines in the review/assessment. The Center should focus on sustaining its progress in this area, as well as improving the quality of the PNMT comprehensive assessments.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	100% 3/3	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	100% 3/3			1/1					1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	100% 3/3			1/1					1/1	1/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	100% 3/3			1/1					1/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	67% 2/3			1/1					0/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	100% 3/3			1/1					1/1	1/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses:	N/A									

	• Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.										
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.				0/1					0/1	0/1

Comments: a. through d., and f. It was positive that, as appropriate, the individuals reviewed were referred to the PNMT in a timely manner, the PNMT conducted timely reviews, and when necessary, conducted timely comprehensive PNMT assessments with the collaboration of disciplines necessary to address the identified issue.

e. For Individual #10, RNs conducted post-hospitalization reviews on 12/23/15, 1/8/16, 1/15/16, and 6/2/16, but evidence was not found of PNMT review of the RN reviews.

h. For the three individuals for whom the PNMT conducted assessments, on a positive note, the PNMT Comprehensive Assessments:

- Reviewed applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification;
- Provided evidence of observation of the individual's supports at his/her program areas; and
- Provided an assessment of current physical status.

Problems with PNMT assessments varied, but in all four assessments, four or more of the following components were missing or incomplete:

- Description of the presenting problem;
- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs;
- Review of 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 their relevance to PNM supports and services;
- 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.

Overall, the PNMT assessments were not well organized with analysis and recommendations scattered throughout and not summarized. This would make it difficult for the IDTs to understand and act upon the assessment information. The PNMT had not consistently identified the etiology/cause of the problem, and the steps necessary to mitigate risk. Similarly, the analysis of the

effectiveness of current supports often was not clear, making it unclear what, if anything, needed to change. The PNMT often did not clearly define individualized clinical indicators to assist IDTs in identifying when the individual was healthy and/or when deterioration was potentially occurring. In addition, it often appeared that various disciplines had completed their own assessments, but had not integrated their findings with other team members' findings and recommendations. At times, recommendations were not well justified or clearly explained. The Center should focus on improving the quality of these assessments.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Minimal improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
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).	44% 8/18	1/2	1/2	1/2	1/2	2/2	1/2	1/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	56% 10/18	2/2	1/2	1/2	1/2	2/2	2/2	1/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	22% 2/9	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	6% 1/18	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	33% 6/18	0/2	2/2	0/2	0/2	1/2	2/2	1/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	56% 10/18	2/2	2/2	1/2	1/2	1/2	1/2	2/2	0/2	0/2
Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: falls, and choking for Individual #45; choking, and falls for Individual #74; aspiration, and falls for Individual #140; choking, and weight for Individual #81; aspiration, and fractures for Individual #71; choking, and fractures for Individual #169; aspiration, and falls for Individual #72; aspiration, and falls for Individual #10; and aspiration, and weight for Individual #70. a. The ISPs/IHCPs reviewed that sufficiently addressed individuals' PNM needs as presented in the PNMT assessment/review or PNMP were those for: falls for Individual #45; falls for Individual #74; falls for Individual #140; choking for Individual #81; aspiration, and fractures for Individual #71; choking for Individual #169; and falls for Individual #72.											

b. The IHCPs that included preventative physical and nutritional management interventions to minimize the individuals' risks were for: falls, and choking for Individual #45; falls for Individual #74; falls for Individual #140; choking for Individual #81; aspiration, and fractures for Individual #71; choking, and fractures for Individual #169; and falls for Individual #72.

c. All individuals reviewed had PNMPs and/or Dining Plans. The PNMPs and/or Dining Plans for Individual #140, and Individual #81 included all of the necessary components to meet the individuals' needs. Problems varied across the remaining PNMPs and/or Dining Plans. For example, two PNMPs indicated the individual was to receive nothing by mouth in the medication administration section, but provided conflicting instructions for oral intake under the mealtime section (i.e., Individual #10, and Individual #70); and a number of PNMPs did not provide complete/accurate communication instructions for staff (e.g., Individual #45, Individual #74, Individual #71, Individual #169, Individual #72, Individual #10, and Individual #70).

d. The IHCP for choking for Individual #169 identified the action steps necessary to meet the identified objectives listed in the measurable goal/objective.

e. The IHCP reviewed that identified the necessary clinical indicators was for falls for Individual #74.

f. The IHCPs that identified triggers and actions to take should they occur were those for: choking, and falls for Individual #74; fractures for Individual #71; choking, and fractures for Individual #169; falls for Individual #72.

g. The IHCPs reviewed that identified the frequency of monitoring/review of progress were those for: falls, and choking for Individual #45; choking, and falls for Individual #74; falls for Individual #140; choking for Individual #81; fractures for Individual #71; choking for Individual #169; and aspiration, and falls for Individual #72.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: The Center had not made progress with these indicators.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/3	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1	0/1
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/3					0/1			0/1	0/1

Comments: a. and b. For Individual #10, and Individual #70, based on review of their PNMPs, it was not clear whether or not they received some oral intake. For Individual #71, his IRRF stated he was nothing-by-mouth status, but required special feeding techniques for nutrition and snacks, which was confusing.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. During the Round 9 review and this review, the Center scored at 100%, and 78%, respectively, with regard to timeliness, and 100% and 100%, respectively, with regard to completing assessments in accordance with the needs of the individuals. However, during Round 10, the Center's score was 44% for both of these indicators. The quality of these assessments was showing improvement. The Monitoring Team will continue to review these indicators, but it was encouraging to see progress.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	78% 7/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills,	N/A									

	oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	63% 5/8	1/1	0/1	N/A	1/1	1/1	1/1	0/1	1/1	0/1

Comments: d. On a positive note, the comprehensive assessment for Individual #140 included all of the necessary components and sufficiently addressed her OT/PT strengths, and needs, and incorporated her preferences.

e. It was also positive that Individual #45, Individual #81, Individual #71, Individual #169, and Individual #10's updates included all of the necessary components, and addressed their strengths, preferences, and needs. On a positive note, the remaining updates included, as appropriate:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports.

With the remaining updates, problems were noted with one or more of the following elements:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- The individual's preferences and strengths are used in the development of OT/PT supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- A functional description of the individual's fine, gross, sensory, and oral motor skills, and activities of daily living with examples of how these skills are utilized throughout the day;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, identification of any changes within the last year to the seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale);
- 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;
- Analysis of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, and assistive/adaptive equipment), including

monitoring findings;

- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires fewer or more services; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.											
Summary: Over the last two reviews and this one, the Center's scores for these indicators varied. It was good to see some improvement from the last review with regard to IDTs reviewing and making changes, as appropriate, to individuals' PNMPs and/or Positioning schedules at least annually, as well as including OT/PT strategies, interventions, and programs in ISP action plans and/or ISPAs. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	22% 2/9	0/1	1/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	62% 8/13	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/3	3/3
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	80% 4/5	N/A	N/A	1/1	N/A	N/A	N/A	1/1	0/1	2/2

Comments: c. and d. Examples of concerns noted included:

- For Individual #140 and Individual #45, the direct PT goal did not appear to be incorporated into an ISP action plan or ISPA.
- For Individual #10, on 1/11/16, direct PT was initiated, but there was no evidence of an ISPA meeting to gain IDT approval to initiate this intervention. However, the IDT did review and approve its continuation at an ISP meeting on 2/2/16.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Given that over the last two review periods and during this review, individuals reviewed had communication assessments or updates in accordance with their needs (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), Indicator b will move to the category of requiring less oversight. The Center should focus on completing timely assessments, and improving the quality of assessments and updates.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	100% 1/1			1/1						
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	67% 6/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports;	N/A									

	• Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	13% 1/8	0/1	0/1	N/A	0/1	1/1	0/1	0/1	0/1	0/1

Comments: d. and e. It was positive that Individual #71's Communication update included all of the necessary components, and addressed his strengths, needs, and preferences. Problems varied across the remaining assessment and updates, but in each one or more of the key components were insufficient to address the individual's strengths, needs, and preferences. Based on the problems identified in the updates reviewed, moving forward, the Facility should focus on ensuring communication assessments and updates address, and/or include updates, as appropriate, regarding:

- 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.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.											
Summary: Over the last two reviews and this one, the Center's scores on these indicators varied. Center staff need to focus on improving the communication aspects of individuals' ISPs.			Individuals:								
#	Indicator	Overall	45	74	140	81	71	169	72	10	70

		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.	44% 4/9	0/1	1/1	1/1	1/1	0/1	0/1	1/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	38% 3/8	0/1	0/1	0/1	0/1	1/1	1/1	0/1	N/A	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	67% 6/9	0/1	0/1	1/1	1/1	2/2	1/1	1/1	N/A	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. For five individuals, their ISPs did not sufficiently incorporate guidelines for communication that were included in the communication assessment.											

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.											
Summary: Each individual had at least one SAP and most were written in measurable terms. Problems with the meaningfulness of SAPs and the collection of reliable, useful data continued to exist. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
1	The individual has skill acquisition plans.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	82% 14/17	2/2	2/2	1/1	2/2	1/2	2/3	2/2	2/2	0/1
3	The individual's SAPs were based on assessment results.	71% 12/17	2/2	0/2	1/1	1/2	1/2	3/3	1/2	2/2	1/1
4	SAPs are practical, functional, and meaningful.	47%	1/2	0/2	1/1	0/2	1/2	2/3	0/2	2/2	1/1

		8/17									
5	Reliable and valid data are available that report/summarize the individual's status and progress.	12% 2/17	0/2	0/2	0/1	1/2	0/2	0/3	1/2	0/2	0/1

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. Only Individual #114 had three SAPs. There was one SAP available to review for Individual #166 and Individual #171. Additionally, there were two SAPs available for Individual #45, Individual #83, Individual #26, Individual #74, Individual #142, and Individual #13, for a total of 17 for this review.

2. The majority of SAPs were measurable. The exceptions were objectives that were not operationally defined (Individual #26's organize personal items and Individual #114's play catch SAPs), and objectives without a prompt level (Individual #166's make a smoothie SAP).

3. Seventy-one percent of the SAPs were based on assessment results. Several SAP assessments, however, suggested that the individual already possessed the skill (e.g., Individual #83's putting clothes in a hamper).

4. Several SAPs were judged not to be practical or functional either because they represented a compliance issue rather than a new skill (e.g., Individual #142's follow directions SAP), or were skills that the individual already had (e.g., Individual #74's pour a drink SAP).

5. The majority of SAPs did not have interobserver agreement (IOA) demonstrating that the data were reliable. The exceptions were Individual #83's call family SAP and Individual #74's pour drink SAP, which had IOA above 80% in the last six months. Additionally, the Monitoring Team observed Individual #142's state time and Individual #171's count coins SAPs, and found that they were scored accurately, however, these SAP data were not found in the monthly report so they were scored as 0. The best way to ensure that SAP data are reliable is to regularly assess IOA (by directly observing DSPs record the data).

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

Summary: These three assessments were current for all individuals, but all were not available to the IDT as required and most did not include recommendations for skill acquisition. This outcome and its indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 13	142	171	74	26	114	83	45	166
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	56% 5/9	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	33%	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1

		3/9									
Comments: 10-12. All individuals had current FSAs, PSIs, and vocational assessments (if appropriate). Several individual's PSIs (e.g., Individual #74's) and/or FSAs (e.g., Individual #13) were not, however, available to the IDT at least 10 days prior to their ISP. Additionally, several individual's FSAs (e.g., Individual #114), and/or vocational assessments (e.g., Individual #74), did not include recommendations for SAPs.											

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

This domain contains 40 outcomes and 176 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. Fifteen of these, in psychiatry, medical, pharmacy, dental, and OT/PT, had sustained high performance scores and will be moved the category of requiring less oversight.

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

Goals/Objectives and Review of Progress
Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical, psychiatric, and/or dental health. Behavioral health services had relevant goals/objectives and also reasonably designed data collection systems, but progress could not be determined because there were not good reliable data available.

Progress reports, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

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

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

Psychiatry and behavioral health services took action when an individual was experiencing or exhibiting psychiatric deterioration and/or behavioral problems. This included the availability and provision of interim psychiatry clinics. There was

ongoing collaboration between psychiatry and neurology. Better collaboration between behavioral health services and psychiatry is needed.

Implementation of Plans

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

Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs. The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessments, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These treatments, interventions, and strategies need to be included in IHCPs, and PCPs need to implement them timely and thoroughly.

It was positive that over the last two review periods and during this review, for the non-Facility consultations reviewed, the PCP generally reviewed consultations and indicated agreement or disagreement, did so in a timely manner, wrote an IPN that included necessary components, and ordered agreed-upon recommendations. This resulted in four indicators moving to the category of requiring less oversight. However, the Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

The Center also needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Problems were noted for the individuals' reviewed with regard to dental care and treatment. The Center should focus on ensuring individuals receive necessary prophylactic dental care, x-rays, fluoride treatment as appropriate, and treatment for periodontal disease. Improvements also are needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. On a positive note, at preventative visits, Dental Department staff provided tooth-brushing instruction to the individuals reviewed and/or their staff. This finding was consistent with the previous two reviews, so this indicator will be placed in the category of requiring less oversight.

Based on the individuals' reviewed, the El Paso SSLC Pharmacy Department was completing QDRRs timely, the overall quality of the QDRRs was good, and practitioners generally reviewed them timely. As a result, three pharmacy indicators will be placed in

the category of requiring less oversight. Implementation of the agreed-upon recommendations from the QDRRs is an area in which the Center needs to continue to improve its performance.

Adaptive equipment was generally clean and in good working order. The two related indicators will be moved to the category of requiring less oversight. Proper fit was sometimes still an issue.

Based on observations, there were still many instances (close to 40% of 51 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

The requirements when an individual has had more than three crisis intervention restraints in any rolling 30-day period were only partially met. By this time, the facility should be meeting these requirements at 100%. Behavioral health services had a system and had set expectations for PBSP implementation integrity. This was good to see, however, the processes had not been implemented and their own goals not yet met.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.												
Summary: This outcome and its indicators applied to three individuals. The required thorough review occurred for two of the three individuals. That is, one individual did not have this important protection provided. Thus, this outcome and its indicators will remain in active monitoring. When reviews were conducted (i.e., for two of the individuals), many, but not all of the required components were evident. More work should be done in this area, especially given the number of restraints that occurred at El Paso SSLC.			Individuals:									
#	Indicator	Overall Score	13	26	142							
18	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, the IDT met within 10 business days of the fourth restraint.	67% 2/3	1/1	1/1	0/1							
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than	67% 2/3	1/1	1/1	0/1							

	three restraints in a rolling 30 days.										
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2	1/1	1/1	N/A						
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2	1/1	1/1	N/A						
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2	0/1	0/1	N/A						
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	50% 1/2	1/1	0/1	N/A						
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	100% 3/3	1/1	1/1	1/1						
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	0% 0/3	0/1	0/1	0/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 2/2	1/1	1/1	N/A						

Comments:
18-29. This outcome and its indicators applied to Individual #13, Individual #26, and Individual #142.

18. ISPAs to address more than three restraints in 30 days should occur within 10 business days of the fourth restraint. Individual #13 had his fourth restraint in 30 days on 4/12/16, and his ISPA met on 4/13/16 to address these restraints. Similarly, Individual #26 had his fourth restraint in 30 days on 4/14/16 and his ISPA meeting to discuss these restraints occurred on 4/20/16. Individual #142 had her fourth restraint in 30 days on 1/18/16, however, there was no documentation of an ISPA meeting to develop a plan to address more than three restraints in 30 days.

19. A sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days for Individual #13 and Individual #26, however, no minutes from an ISPA to address more than three restraints in 30 days were available for Individual #142.

20. Individual #13's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, and included action (i.e., the use of visual cues) to address these potential contributing variables. Individual #26's ISPA following more than three restraints in 30 days had minutes reflecting a discussion of adaptive skills, and biological, medical, and/or psychosocial issues that potentially contributed to his restraints, and concluded that these variables did not contribute to his restraints. There was no ISPA to review for Individual #142.

21. Individual #13 and Individual #26's ISPAs following more than three restraints in 30 days reflected a discussion of contributing environmental variables (i.e., noisy and chaotic environments), and concluded that these variables did not contribute to their restraints. There was no ISPA to review for Individual #142.

22. Individual #26's ISPA minutes included a discussion of a potential antecedent condition that was hypothesized to contribute to his restraints (interactions with another individual), however, no actions to address that antecedent was documented in the ISPA. Individual #13's ISPA following more than three restraints in 30 days did not reflect a discussion of potential antecedents of the dangerous behaviors that provoked his restraints. There was no ISPA to review for Individual #142.

23. Individual #13's ISPA minutes reflected a discussion among the IDT of potential maintaining variables (i.e., getting away from staff), and his ISPA documented an action plan to teach Individual #13 how to tell staff to give him space. Individual #26's ISPA did not address potential maintaining variables of the behaviors that provoked his restraint. There was no ISPA to review for Individual #142.

28. Individual #26 did have a recent treatment integrity assessment that was above 80%, however, his ISPA following more than three restraints in 30 days indicated that the IDT believed his plan was not being implemented with integrity. Individual #13's treatment integrity was below 80% in both April 2016 and May 2016. Individual #142's PBSP did not have evidence of a treatment integrity assessment.

29. Individual #26 and Individual #13's ISPAs indicated that their IDT reviewed their PBSPs. Individual #142 did not have an ISPA to address more than three restraints in 30 days.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: Reiss screens were routinely conducted a number of years ago for most, if not all, individuals at El Paso SSLC. Consideration should be given to conducting a Reiss screen again when the individual has had a change in status. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	45	71	70	169					
1	If not receiving psychiatric services, a Reiss was conducted.	100% 4/4	1/1	1/1	1/1	1/1					
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	0% 0/1	0/1	N/A	N/A	N/A					
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	0% 0/1	0/1	N/A	N/A	N/A					
Comments: 1. Of the 16 individuals reviewed by both Monitoring Teams, four individuals were not receiving psychiatric services. All four of these individuals were initially assessed utilizing the REISS screen. 2-3. Individual #45's initial REISS screen was performed 10/20/12. At that time, there was no reported need for a psychiatric evaluation. Since that time, however, Individual #45 experienced significant changes in her health status. As a result, a repeat REISS screen should have been performed.											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledged that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for some individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
10	If the individual was not making progress, worsening, and/or not	63%	1/1	0/1	1/1	1/1	0/1	0/1	1/1	N/A	1/1

	stable, activity and/or revisions to treatment were made.	5/8									
11	Activity and/or revisions to treatment were implemented.	63% 5/8	1/1	0/1	1/1	1/1	0/1	0/1	1/1	N/A	1/1

Comments:
8-9. Without measurable goals and objectives, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. Despite the absence of measurable goals, it was apparent that when some individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments, suggestions for non-pharmacologic approaches) were developed and implemented. There were some examples where revisions to treatment were considered, but not specifically recommended or implemented. For example, it was considered that Individual #114's behavioral challenges were maintained by communication deficits. Record review and observation of Individual #114 did not reveal augmented communication. Similarly, actions regarding dialectical behavioral therapy and/or medications changes were not evident (Individual #142, Individual #26).

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

Summary: These indicators, regarding psychiatrist participation with behavioral health services, requires more focused attention. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 13	142	171	74	26	114	83	45	166
23	Psychiatric documentation references the behavioral health target behaviors, and the functional behavior assessment discusses the role of the psychiatric disorder upon the presentation of the target behaviors.	38% 3/8	0/1	0/1	0/1	1/1	0/1	0/1	1/1	N/A	1/1
24	The psychiatrist participated in the development of the PBSP.	29% 2/7	0/1	0/1	N/A	0/1	0/1	0/1	1/1	N/A	1/1

Comments:
23. While the target behaviors (e.g., behavioral challenges) identified for monitoring were consistent, what was lacking is how these behaviors related to the specific psychiatric diagnosis.

24. In the cases of Individual #83 and Individual #166, the psychiatrist referenced the PBSP in either/both annual evaluations and quarterly clinical documentation.

Outcome 8 – Individuals who are receiving medications to treat both a psychiatric and a seizure disorder (dual use) have their treatment coordinated between the psychiatrist and neurologist.

Summary: These indicators met criterion for this review period. If performance is sustained, it is likely these will move to the category of less oversight after the next	Individuals:

review. At this time, they will remain in active monitoring.											
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 5/5	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A	N/A
26	Frequency was at least annual.	100% 5/5	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A	N/A
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 5/5	1/1	N/A	1/1	N/A	1/1	1/1	1/1	N/A	N/A

Comments:
25-27. This outcome addresses the coordination between psychiatry and neurology. These indicators applied to five of the individuals. The facility had a combined neurology/psychiatry clinic that had been consistently held for several years.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: Quarterly psychiatry clinics occurred regularly. The review documentation needed focused attention. These three indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
33	Quarterly reviews were completed quarterly.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
34	Quarterly reviews contained required content.	13% 1/8	1/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	67% 2/3	N/A	N/A	N/A	N/A	0/1	1/1	1/1	N/A	N/A

Comments:
33. Individuals were generally seen quarterly in a timely manner.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing one to three components; most commonly, a review of the implementation of non-pharmacological interventions, and the description of symptoms that support the psychiatric diagnosis.

35. Neuro/psychiatry clinic was observed for Individual #26, Individual #114, and Individual #83. In the case of Individual #26, data provided were stale, and given the difficulties this individual was experiencing, data that were contemporaneous were necessary. Otherwise, the clinics observed were comprehensive and included good leadership from the psychiatrist and good participation from attendees.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	75% 6/8	1/1	1/1	1/1	1/1	1/1	0/1	0/1	N/A	1/1
Comments: 36. Assessments were generally occurring in a timely manner. In the case of Individual #74, although completed on time, the MOSES did not indicate issues with urinary retention, although this had been a significant issue for this individual. In the case of Individual #114, the MOSES dated 2/12/15 was not signed until 3/25/15. In the case of Individual #83, both the MOSES and DISCUS assessments were performed approximately one month after they were due.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: El Paso SSLC met criteria for these three indicators and has done so for a number of years. These three indicators will move to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
37	Emergency/urgent and follow-up/interim clinics were available if needed.	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?	100% 5/5	1/1	1/1	N/A	1/1	1/1	1/1	N/A	N/A	N/A
Comments: 37-39. There was evidence of additional psychiatric reviews when an individual was clinically unstable or when medication adjustments had been made.											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These indicators met criteria during this review. They will, however, remain in active monitoring. Some may be considered for less oversight after the next review.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
40	Daily medications indicate dosages not so excessive as to suggest goal	100%	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1

	of sedation.	8/8									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
40-41. There was no indication that the facility used psychotropic medication to sedate individuals for the convenience of staff or for punishment.

43. 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.

Summary: Polypharmacy management activities were occurring as per the criteria of these indicators. With sustained performance, these indicators might be categorized as requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 13	142	171	74	26	114	83	45	166
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 5/5	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A	1/1
45	There is a tapering plan, or rationale for why not.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1
46	The individual was reviewed by polypharmacy committee (a) at least quarterly if tapering was occurring or if there were medication changes, or (b) at least annually if stable and polypharmacy has been justified.	100% 5/5	1/1	N/A	N/A	N/A	1/1	1/1	1/1	N/A	1/1

Comments:
44-45. These indicators applied to five individuals. Polypharmacy justification was appropriately documented in all five cases. Justifications were well written and comprehensive. They included a description of the receptor/biochemical activity of the medication. This was good to see.

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of thorough committee review for all individuals meeting criteria for polypharmacy.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Given the absence of good, reliable data, progress could not be determined for five individuals. For the one individual who had good, reliable data, progress was not occurring. The Monitoring Team scored indicators 8 and 9 based upon the facility's report of progress/lack of progress as well as the ongoing exhibition of problem target behaviors. The indicators in this outcome will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
6	The individual is making expected progress	0% 0/6	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	100% 4/4	1/1	1/1	N/A	N/A	1/1	N/A	N/A	N/A	1/1
9	Activity and/or revisions to treatment were implemented.	75% 3/4	0/1	1/1	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments:

6. Available data indicated that Individual #13, Individual #142, Individual #26, and Individual #166 were making progress in some target behaviors, however, the data were not demonstrated to be reliable (see indicator #5), so these individuals were not scored as progressing. Individual #114's data were documented to be reliable, however, he was not making progress. Individual #83 was not making progress and her data were not demonstrated to be reliable.

8. The Monitoring Team was encouraged to see that Individual #26, Individual #166, Individual #13, and Individual #142 had actions suggested in their progress notes to address behavioral issues. For example, Individual #142's progress note suggested adding a behavioral contract to her PBSP to increase compliance.

9. There was evidence that the actions suggested to address Individual #26, Individual #166, and Individual #142's lack of progress were implemented. Individual #13's progress note suggested modifications to his PBSP, however, there was no evidence that those changes were implemented.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.	
Summary: Staff training and provision of information for float staff did not meet criteria. It was good to see that the facility had behavioral health specialists who	

were certified or in the certification process. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
16	All staff assigned to the home/day program/work sites (i.e., regular staff) were trained in the implementation of the individual's PBSP.	0% 0/6	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A	0/1
17	There was a PBSP summary for float staff.	0% 0/6	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A	0/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1

Comments:

16. None of the individuals had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained on the its implementation.

17. None of the individuals had evidence of an abbreviated PBSP for float staff to review.

18. All individuals' functional assessments and PBSPs were written by a behavioral specialist who was enrolled in, or had completed BCBA coursework. Additionally, all functional assessments and PBSPs were signed off by a BCBA.

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: It was good to see that behavioral health services progress notes included comments on the progress of individuals. The preparation, use, and inclusion of data and data graphs did not meet criteria. Internal peer review met criteria, but external peer review did not. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
19	The individual's progress note comments on the progress of the individual.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
20	The graphs are useful for making data based treatment decisions.	17% 1/6	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	67% 2/3	N/A	N/A	N/A	N/A	0/1	1/1	1/1	N/A	N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of	0% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	recommendations made in peer review.										
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:
19. All individuals had progress notes that commented on the individual's progress.

20. All progress notes had graphs. Individual #166's graphs were judged to encourage data based decisions by including indications of the occurrence of important environmental changes (e.g., medication changes) and clearly indicating trends. The usefulness of Individual #83, Individual #13, and Individual #142's graphs, however, was limited because the scale obscured behavioral trends. Individual #26 and Individual #114's graphs included multiple data paths that obscured trends.

21. In order to score this indicator, the Monitoring Team observed Individual #114, Individual #83, and Individual #26's psychiatric clinic meetings. In Individual #114 and Individual #83's meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team. Individual #26's data, however, did not include the last two weeks of data resulting in the behavioral specialist not being able to respond to IDT's questions regarding his most recent behavioral data.

22. The minutes from Individual #142's February 2016 peer review suggested the development of several new skill acquisition plans that would contribute to reductions in her behavioral targets. There was not, however, evidence of follow-up/implementation those recommendations.

23. El Paso SSLC had documentation that internal peer review meetings were consistently occurring weekly, however, there was not documentation that external peer review meetings were occurring monthly.

Outcome 8 – Data are collected correctly and reliably.											
Summary: El Paso SSLC PBSPs had adequately designed measures of target and replacement behaviors, as well as established goals for various determinations of integrity of treatment implementation and data collection. This was good to see. The goal levels were not yet achieved. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1

#	Indicator	Overall Score									
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 6/6	1/1	1/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	0% 0/6	0/1	0/1	N/A	N/A	0/1	0/1	0/1	N/A	0/1

Comments:

29. El Paso SSLC established that IOA, DCT, and treatment integrity assessments would be assessed at least monthly, and the minimum goal level was determined to be 80%.

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were not achieved for any individuals. Some individuals had IOA and/or treatment integrity scores collected monthly, however, the last assessment had scores below 80% (e.g., Individual #13). When IOA, treatment integrity, or date collection timeliness are below the minimal level, staff should be immediately retrained and the assessment re-administered. Other individuals had IOA and/or treatment integrity scores above the minimum level, however, they were not administered at the goal frequency (e.g., Individual #26). Finally, none of the individuals had data collection timeliness measures reported.

Medical

Outcome 1 – Individuals with chronic and/or at-risk conditions requiring medical interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

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

			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	11% 2/18	0/2	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	6% 1/18	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	6% 1/18	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/17	0/2	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review [i.e., Individual #45 – diabetes, and osteoporosis; Individual #74 – other: hypothyroidism, and osteoporosis; Individual #140 – seizures, and constipation/bowel obstruction; Individual #81 – diabetes, and respiratory compromise/aspiration; Individual #71 – infections, and constipation/bowel obstruction; Individual #169 – osteoporosis, and gastrointestinal (GI) problems; Individual #72 – infections, and diabetes; Individual #10 – infections, and diabetes; and Individual #70 – osteoporosis, and other: hydrocephalus]. From a medical perspective, the goal/objective that was clinically relevant, achievable, and measurable was for: Individual #74 – osteoporosis. Although the following goal/objective was measurable, because it was not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #81 – aspiration. c. through e. Individual #74 had a clinically relevant and measurable goal/objective related to his diagnosis of osteopenia. Testing in November 2015 showed that his Bone Mineral Density (BMD) improved. Although this was not reflected in the ISP monthly review, he met this goal/objective. However, his hypothyroidism was not addressed in his IRRF or IHCP. For individuals without clinically relevant, measurable goals/objectives, IDTs could not measure progress. In addition, progress reports on these goals, including data and analysis of the data, were not available to IDTs in an integrated format. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As a result, the Monitoring Team conducted full reviews of the processes related to the provisions of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
Summary: Five of the nine individuals reviewed received the preventative care they needed. The overall percentages represented a slight reduction from the last two reviews. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to preventative care can be assessed and are deemed to meet the requirements of the Settlement Agreement. In addition, the Facility needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual receives timely preventative care:										

	i. Immunizations	67% 6/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1
	ii. Colorectal cancer screening	100% 5/5	1/1	1/1	N/A	N/A	1/1	N/A	1/1	1/1	N/A
	iii. Breast cancer screening	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
	v. Hearing screen	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	67% 2/3	1/1	N/A	1/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- For Individual #74, no documentation was found of varicella or Prevnar 13.
- For Individual #71, no documentation was found of administration of Prevnar 13, despite a history of recurrent pneumonia.
- For Individual #169, authorization to decline pap testing was completed over the telephone. With a decision to refuse treatment, the LAR/individual should have the opportunity to read/review the risks and benefits of treatment and have the opportunity to ask the clinician questions regarding treatment or refusal of it. From the documentation provided, it did not appear this occurred.
- Individual #10 had diabetes mellitus, but his vision screenings were done 16 months apart (i.e., 10/15/14 and 2/22/16). In addition, no Prevnar 13 was documented for this individual with a diagnosis of pneumonia and history of respiratory failure.

Comments: b. As noted in the Medical Audit Tool, in addition to reviewing the Pharmacist's findings and recommendations in the QDRRs, evidence needs to be present that the prescribing medical practitioners have addressed the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: N/A			Individuals:								
#	Indicator	Overall	45	74	140	81	71	169	72	10	70

		Score									
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: None.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Given that over the last two review periods and during this review, when individuals were transferred to the hospital, the PCP or a nurse generally communicated necessary clinical information with hospital staff (Round 9 – 100% for Indicator 4.f, Round 10 – 100% for Indicator 4.f, and Round 11 -80% for Indicator 6.f), Indicator f. will move to the category of requiring less oversight. However, overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Facility and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual experiences an acute medical issue that is addressed at the Facility, the PCP or other provider assesses it according to accepted clinical practice.	50% 6/12	2/2	0/1	2/2	0/1	N/A	1/1	0/2	1/2	0/1
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.	67% 8/12	2/2	1/1	2/2	0/1		1/1	0/2	1/2	1/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, <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.	60% 3/5	N/A	1/1	1/1	N/A	0/1	N/A	N/A	0/1	1/1
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	67% 2/3		0/1	1/1		N/A			N/A	1/1

e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	40% 2/5		1/1	1/1		0/1			0/1	0/1
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	80% 4/5		1/1	1/1		0/1			1/1	1/1
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	40% 2/5		0/1	0/1		1/1			0/1	1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	50% 2/4		1/1	1/1		N/A			0/1	0/1

Comments: a. and b. For the eight individuals reviewed in relation to medical care, the Monitoring Team reviewed 12 acute illnesses addressed at the Facility, including the following with dates of occurrence: Individual #45 (vaginitis on 3/24/16, and allergic rhinitis on 1/29/16), Individual #74 (laceration/self-injurious behavior on 4/4/16), Individual #140 (finger laceration on 5/11/16, and blepharitis on 3/3/16), Individual #81 (fever on 5/6/16), Individual #169 (cerumen impaction on 12/28/15), Individual #72 (UTI on 5/9/16, and hypotension on 5/3/16), Individual #10 (dehydration on 12/2/15, and pressure ulcer on 3/28/16), and Individual #70 (UTI on 4/18/16).

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #45 (vaginitis on 3/24/16, and allergic rhinitis on 1/29/16), Individual #140 (finger laceration on 5/11/16, and blepharitis on 3/3/16), Individual #169 (cerumen impaction on 12/28/15), and Individual #10 (pressure ulcer on 3/28/16). For many of the remaining acute illnesses treated at the Facility that the Monitoring Team reviewed, common problems included a lack of a focused physical examination, including documentation of all positive and negative findings; failure to review and summarize the most recent diagnostic tests, including normal or negative results; a lack of definitive or differential diagnosis that clinically fit the corresponding evaluation or assessment(s); and/or a lack of a plan for further evaluation, treatment, and monitoring, including detail, as needed, regarding the monitoring the PCP and/or nursing staff were expected to complete.

The acute illnesses/occurrences reviewed for which follow-up was needed, and documentation was found to show the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized included those for Individual #45 (vaginitis on 3/24/16, and allergic rhinitis on 1/29/16), Individual #74 (laceration/self-injurious behavior on 4/4/16), Individual #140 (finger laceration on 5/11/16, and blepharitis on 3/3/16), Individual #169 (cerumen impaction on 12/28/15), Individual #10 (pressure ulcer on 3/28/16), and Individual #70 (UTI on 4/18/16).

The following provide examples of concerns noted:

- On 12/2/15, the PCP evaluated Individual #10 for multiple episodes of emesis. The assessment resulted in a diagnosis of acute gastritis. As-needed or pro re nata (PRN) Phenergan was prescribed and labs were ordered. On 12/4/15, the clinic PCP

documented the findings of the labs, which indicated pre-renal azotemia and significant hypercalcemia, based on the adjusted calcium level. An intravenous infusion of normal saline was ordered and calcium supplementation was held. On 12/5/15, the clinic PCP documented that two liters of normal saline were given and labs were being re-checked. On 12/7/15, the PCP noted that the individual was lethargic and very drowsy. The calcium was reported to be 10.8, but there was no indication that this was an adjusted calcium level. The assessment was dehydration and slow gastric emptying. An infusion of intravenous D5W was ordered for treatment of dehydration. On 12/8/15 and 12/9/15, follow-up occurred, at which time it was documented that the individual was lethargic and weak. An uncorrected calcium level was documented and it was determined that the hypocalcemia was resolved. On 12/14/15, the follow-up assessment lacked a complete set of vital signs. On 12/15/15, the individual was transferred to the ED for evaluation of electrolyte abnormalities and admitted with pneumonia, electrolyte abnormalities, and altered mental status.

This individual had significant hypercalcemia (13.6) that required aggressive management, monitoring of urine output, and follow-up. The initial management, as ordered, was with the infusion of normal saline. It was documented over a period of days that the individual was lethargic and weak, but vital signs and urine output were not documented in the IPNs reviewed.

- On 4/28/16, the PCP for Individual #72 noted that labs showed evidence of hypocalcemia. Labs were repeated. On 5/3/16, the individual was seen due to a blood pressure that decreased from baseline. The electrocardiogram (EKG) was noted to be unchanged. On 5/4/16, the individual was seen for clear nasal discharge. The individual's temperature was documented, but there was no follow-up of the low blood pressures. On 5/5/16, it was noted that the concern of blood pressure was discussed with the clinic internal medicine physician and the decision was made to discontinue doxazosin. There was no follow-up on this. The next and last note related to foul smelling urine. No blood pressures were documented for that evaluation. On 5/9/16, the PCP documented that Individual #72 was being evaluated for foul smelling urine. The plan was to obtain a urinalysis and treat accordingly. There were no additional PCP entries in the record. The lab reports revealed that a urinalysis done on 5/9/16 had 15 to 20 white blood cells with a culture positive for enterobacterciae. A repeat urinalysis done on 5/20/16 showed too numerous to count (TNTC) white blood cells with a culture positive for E.coli. There was no documented assessment related to signs and symptoms of illness. The only medical assessment identified was the one completed on 5/9/16. On 5/31/16, Individual #72 experienced cardiac arrest at the Facility. Resuscitation was not successful, and he died at the age of 63. At the time of the Monitoring Team's onsite review, the causes of death were pending.

For five of the nine individuals reviewed, the Monitoring Team reviewed five acute illnesses requiring hospital admission or ED visit, including the following with dates of occurrence: Individual #74 (nasal fracture on 5/20/16), Individual #140 (aspiration pneumonia, respiratory failure, and septic shock on 12/10/15), Individual #71 (aspiration pneumonia/respiratory failure on 4/13/16), Individual #10 (hypoxia on 1/12/16), and Individual #70 (aspiration pneumonia/respiratory failure on 2/8/16).

c. For Individual #71 (aspiration pneumonia/respiratory failure on 4/13/16), no PCP IPN was included at the time of his transfer to the hospital, which was during business hours. For Individual #10 (hypoxia on 1/12/16), the transfer occurred after hours, but no IPN was found within 24 hours.

d. Two of the acute illnesses reviewed occurred after hours or on a weekend/holiday. The only vital sign documented in the IPNs was temperature for Individual #74 (nasal fracture on 5/20/16).

The following provide examples of concerns noted:

- On 3/16/16, nursing documented that Individual #71 had not had a bowel movement for three days. A suppository was administered and produced results. On 3/29/16, a suppository was given again for the same indication. There was documentation of constipation over a period of weeks. On 4/7/16, the first physician evaluation was noted. On 4/8/16, the individual was seen again at which time there was a change made in the bowel regimen and the plan was for as-needed follow-up. On 4/11/16, the individual was seen again due to a history of cough. The PCP documentation noted that the individual had oxygen saturation rates ranging from 89 to 90%. There was no documentation of vital signs. The physical exam was pertinent for the presence of right upper lobe rhonchi with diminished lung sounds in all other lobes. The plan was to check a chest x-ray and x-ray of the kidney, ureter, and bladder (KUB) and administer respiratory treatments. Follow-up was scheduled for 4/15/16. The medical documentation did not indicate that Individual #71 had experienced emesis and was placed on the emesis protocol as nursing staff documented. On 4/13/16, nursing staff documented that the individual had emesis and had respiratory difficulties with oxygen saturation rates of 83 to 89% on a two-liter nasal cannula. Individual #71 was admitted to the hospital with aspiration pneumonia and respiratory failure that required mechanical ventilation for a prolonged period. On 5/9/16, he was discharged to hospice with an out-of-hospital DNR. At the time of the Monitoring Team's record request, he remained in hospice.
- Individual #10 was hospitalized from 12/15/15 to 12/21/15 with acute respiratory failure, pneumonia, and altered mental status. On 12/21/15, he returned to EPSSLC, and on 12/22/15, he was reevaluated. On 12/23/15, he was noted to be lethargic and have a low blood pressure. He was referred to the ED again and remained in the hospital until 1/7/16. On 1/8/16, there was a post-hospital assessment documented. There was no other follow-up documented. On 1/12/16, nursing documented that the individual was being referred to the hospital. IPN documentation indicated the diagnosis was hypoxia/pneumonia. On 1/14/16, Individual #10 returned to the Facility and the PCP assessed him. The next IPN entry was on 1/22/16, and was related to labs. The abnormal albumin level was not addressed.
- On 2/8/16, the PCP documented that Individual #70 was being seen in clinic due to multiple episodes of emesis and seizure activity on 2/7/16. The diagnosis was acute gastritis, mild dehydration, and hypokalemia. IVF (D5W) was continued. On 2/9/16, the individual was re-evaluated and noted to have continued emesis and labs showed a leukocytosis and significant hyponatremia. The individual was transported to the hospital and admitted with septic shock, aspiration pneumonia, and respiratory failure that required mechanical ventilation. On 3/22/16, Individual #70 returned to the Facility, and on 3/23/16, the PCP saw him. The post-hospital note did not summarize the assessment and treatment that occurred during the prolonged hospital stay. Moreover, the individual's blood pressures were documented to be low (70/36 and 80/40), and there was no plan to address this. Follow-up occurred on 3/24/16 and 3/26/16, at which time it was noted that the blood pressure had improved to 112/64.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.	
Summary: Given that over the last two review periods and during this review, for the consultations reviewed, the PCP generally reviewed consultations and indicated agreement or disagreement (Round 9 – 88%, Round 10 – 88%, and Round 11 – 89%), did so in a timely manner (Round 9 – N/A, Round 10 – 71%, and Round 11 –	Individuals:

89%), wrote an IPN that included necessary components (Round 9 – 100%, Round 10 – 94%, and Round 11 – 78%), and ordered agreed-upon recommendations (Round 9 – 100%, Round 10 – 100%, and Round 11 – 100%), Indicators a, b, c, and d will move to the category of requiring less oversight. The Facility needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	89% 16/18	2/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2	1/2
b.	PCP completes review within five business days, or sooner if clinically indicated.	89% 16/18	2/2	1/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the recommendation(s), and whether or not there is a need for referral to the IDT.	78% 14/18	2/2	2/2	2/2	1/2	1/2	1/2	2/2	2/2	1/2
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.	100% 16/16	2/2	2/2	2/2	1/1	2/2	2/2	2/2	2/2	1/1
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/2	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #45 for gastroenterology (GI) on 5/18/16, and gynecology on 1/6/16; Individual #74 for neurology on 3/4/16, and podiatry on 2/25/16; Individual #140 for orthopedics on 6/1/16, and orthopedics on 5/23/16; Individual #81 for ear, nose, and throat (ENT) on 4/13/16, and ENT on 4/26/16; Individual #71 for hematology on 4/7/16, and eye on 2/23/16; Individual #169 for eye on 4/12/16, and GI on 1/15/16; Individual #72 for ENT on 3/23/16, and GI on 3/17/16; Individual #10 for pulmonary on 5/11/16, and wound clinic on 4/19/16; and Individual #70 for neurosurgery on 5/19/16, and neurology on 4/12/16.

a. It was positive that PCPs generally reviewed and initialed the consultation reports reviewed, and indicated agreement or disagreement with the recommendations. The exception was the consultation for Individual #81 for ENT on 4/13/16, and Individual #70 for neurosurgery on 5/19/16 for which agree/disagree was blank.

b. The consultations for which this was not done timely were for Individual #74 for podiatry on 2/25/16, and for Individual #81 for ENT on 4/13/16.

c. For Individual #81 for ENT on 4/13/16, no IPN documentation was submitted. For Individual #71, for his eye consultation on

2/23/16, the IDT section was blank. For Individual #169, and Individual #70 for neurosurgery on 5/19/16, the IPN documentation was not complete.

d. When PCPs agreed with consultation recommendations, evidence was submitted to show orders were written, which was good to see.

e. The following concerns were noted:

- For Individual #45, according to the consult, the gynecology oncologist discussed the use of high dose-rate (HDR) vaginal brachytherapy for treatment of endometrial carcinoma. The consult dated, 1/6/16, documented that the cylinder was unable to be placed due to a lack of cooperation. "No plans for HDR brachytherapy. Pt. [patient] cannot cooperate." The PCP agreed with this decision, but did not refer the matter to the IDT.
- For Individual #70, on 5/19/16, the PCP documented that the magnetic resonance imaging (MRI) the neurologist ordered was cancelled due to the risks related to general anesthesia. On the same date, the PCP documented that the consulting neurosurgeon agreed with the need to obtain an MRI due to worsening hydrocephalus. An IPN stated a referral to IDT would be made, but there was no ISPA documentation showing discussion of this issue.

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

Summary: The Center needs to focus on ensuring individuals with chronic conditions or at high or medium risk for health issues receive medical assessment, tests, and evaluations consistent with current standards of care, and that PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible.

#	Indicator	Overall Score	Individuals: 45	74	140	81	71	169	72	10	70
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	22% 4/18	1/2	1/2	1/2	0/2	0/2	1/2	0/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #45 – diabetes, and osteoporosis; Individual #74 – other: hypothyroidism, and osteoporosis; Individual #140 – seizures, and constipation/bowel obstruction; Individual #81 – diabetes, and respiratory compromise/aspiration; Individual #71 – infections, and constipation/bowel obstruction; Individual #169 – osteoporosis, and GI problems; Individual #72 – infections, and diabetes; Individual #10 – infections, and diabetes; and Individual #70 – osteoporosis, and other: hydrocephalus).

a. Medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible for the following individuals' chronic diagnoses and/or at-risk conditions: Individual #45 – osteoporosis, Individual #74 – osteoporosis, Individual #140 – constipation/bowel obstruction, and Individual #169 – GI problems. The following provide examples of concerns noted regarding medical assessment, tests, and evaluations, as well as identification of interventions and strategies to

address individuals' at-risk conditions and chronic diagnoses:

- According to the AMA, Individual #45 had borderline Type II diabetes and was prescribed no medications to address it. The last HbA1c listed in the AMA was 5.9, which is consistent with pre-diabetes. Management should include lifestyle modifications, including weight loss, and increasing physical activity. Additionally, per the American Diabetes Association Standards of Medical Care in Diabetes - 2016, Metformin therapy for prevention of type 2 diabetes should be considered in those with pre-diabetes, especially in those with body mass index (BMI) .35 kg/m2, and those aged 60 years. Consideration of such treatment was not documented in the AMA. In addition, HbA1c levels have not been monitored appropriately, with the last being obtained in 9/15/15.
- Individual #74 appeared to have difficulty with the management of hypothyroidism. Multiple dose changes of medication were documented. Multiple thyroid stimulating hormone levels were documented, but the individual was not biochemically euthyroid and no referral was made to an endocrinologist.
- Individual #140 had a history of intractable seizures secondary to Lennoux-Gaustat Syndrome and had a vagus nerve stimulator (VNS). While the individual was seen frequently in the on-site neurology clinic, there was no documentation that an epileptologist had recently evaluated the individual. The individual had a recent history of status epilepticus per hospital records. The respiratory failure was attributed to aspiration that occurred when the individual experienced a seizure while eating.
- According to the IRRF, the IDT rated Individual #81 at low risk for diabetes. However, he met three criteria for metabolic syndrome, including increased triglycerides, increased waist circumference, and low high-density lipoprotein (HDL). The individual continued to be treated with a new generation antipsychotic. The AMA, and quarterly medical summaries did not address obesity or abnormal lipid status.
- Similarly, Individual #72's IDT rated him as at low risk for diabetes. However, the AMA documented a history of borderline diabetes mellitus in one component and pre-diabetes in another. The individual met the American Diabetes Association's (ADA) criteria for the diagnosis of pre-diabetes. Interventions such as increased activity and caloric restriction were included in the plan; however, there was no discussion of the risk/benefit ratio of implementing medical therapy as outlined in the ADA guidelines.
- Individual #71's IDT rated him as being at high risk for infections, but LTBI was not discussed in the IRRF. According to the AMA, the individual had tuberculosis encephalitis as an infant. There was no documentation of the treatment. The AMA stated that the individual had a negative chest x-ray in 2015, and was seen by public health in 2013 and determined not to be a candidate for treatment. The AMA did not provide any information on the surveillance for reactivation of tuberculosis (TB) infection. The nursing assessment noted that an annual TB questionnaire was completed. However, the use of this screening tool should be included as part of the IHCP.
- Similarly, Individual #72's IRRF did not include any risk related to LTBI. The AMA noted the following: "Quantiferon gold test on 9/4/12 was positive. There is mention of tuberculosis in 1979; however it appears that this was a positive PPD. He was seen by public health on 9/14/12 who recommended that he is not a candidate for latent TB treatment." The AMA did not document if the individual received treatment for LTBI in the past. The IRRF/IHCP and AMA did not document a plan for monitoring this individual for re-activation of tuberculosis. Staff should be aware of the signs and symptoms that must be reported and a TB questionnaire should be completed annually.
- In addition, Individual #10's AMA indicated that the individual had a history of a positive PPD without active disease. In October 2015, sputum was negative and the chest x-ray done in December 2015 did not show acute changes. It was reported

that the individual was evaluated by public health in 2011, and was determined not to be a candidate for LTBI treatment. The individual had a pulmonary consult in May 2016, due to recurrent aspiration and the development of bronchiectasis. The history of LTBI did not appear in the history of the consultant. It is unclear when the diagnosis of LTBI was initially made. However, any individual with a history of infection (particularly those who are not treated) must be monitored for reactivation of infection. It is also important that the pulmonary consultant be provided the history of LTBI. The IHCP provided instructions for direct support professionals and nurses to monitor for signs and symptoms of active TB.

- Individual #71 also had a history of gastroparesis and constipation. The number of suppositories utilized increased, but the AMA plan did not address this issue. The AMA indicated that the problem was stable and the plan was to continue without changes. There was no discussion of non-pharmacologic interventions or changes in the medication regimen. Nursing documentation indicated frequent episodes of constipation that required the use of suppositories. The individual vomited, aspirated and had respiratory failure in April 2016.
- Documentation showed that Individual #169 had worsening bone mineral density while receiving treatment with Prolia. She was referred to the Facility's Internal Medicine physician who documented "consider endocrine consult." It was unclear why the individual was not referred to a specialist for further evaluation, given a decrease of bone mineral density while on therapy. It was also noted that the previous bone mineral density test was completed in March 2013. The current study was done on 2/1/16 (as recommended in the December 2015 QDRR), a year later than guidelines recommend.
- Per the PCP's IPNs, the part-time Internal Medicine physician followed Individual #10 for insulin-dependent diabetes mellitus. On 3/5/16, nursing staff reported hypoglycemia and emesis. This was documented over multiple days, but no physician evaluation was documented. On 3/9/16, the PCP gave an order for intramuscular (IM) glucagon for the treatment of hypoglycemia. The first PCP documentation was on 3/14/16, and it noted the record was reviewed and the "Patient not seen." Changes were made in the medication regimen due to continued hypoglycemia. On 3/17/16, the PCP documented a lab review noting the individual is dehydrated and followed by Internal Medicine for insulin-dependent diabetes mellitus and nephropathy. On 3/17/16, an Internal Medicine consult was done. On 3/21/16, the individual was sent to the ED for a gastrostomy tube (G-tube) replacement and was seen in clinic the following day for follow-up. Nursing staff continued to document significant hypoglycemia through May 2016. Overall, there was little documentation by the primary care providers related to the brittle status of this individual's diabetes mellitus. The care was referred to Internal Medicine. When control continued to be problematic, there was no referral to endocrinology. The basic assessments/diagnostics required for disease management of this individual were also not completed in a timely manner (e.g., annual eye exam, A1c, and bone mineral density). Moreover, the primary care of this individual was very fragmented with two providers assuming responsibility for primary care in addition to internal medicine consults from the part-time physician. There was a perpetual cycle of orders implemented, discontinued and re-implemented, based on the provider seeing the individual.
- Individual #70 had a history of a seizure disorder and was prescribed valproic acid. Per the AMA, the individual's last seizure was in 2011. The individual had worsening hydrocephalus and the neurologist ordered an MRI of the brain and later cancelled the study due to the risk of general anesthesia. On 5/19/16, the neurosurgeon noted that an MRI was needed. Documentation showed that this issue was referred to the IDT for discussion, but the PCP never followed-up.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. In addition, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	28% 5/18	1/2	1/2	2/2	0/2	0/2	1/2	0/2	0/2	0/2
	Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. Those action steps assigned to the PCPs that were identified for the following individuals' risk areas were implemented: Individual #45 – osteoporosis; Individual #74 – osteoporosis; Individual #140 – seizures, and constipation/bowel obstruction; and Individual #169 – GI problems.										

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/A									
	Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.										

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.	
Summary: Given the timely completion of QDRRs at El Paso SSLC (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), as well as the overall quality of the QDRRs (averages for Round 9 – 85%, Round 10 – 98%, and Round 11 - 93%), and	Individuals:

timely practitioner review (Round 9 – 96%, Round 10 – 100%, and Round 11 - 100%), indicators a, b, and c will be placed in the category of requiring less oversight. Implementation of the agreed-upon recommendations is an area in which the Center needs to continue to improve its performance.											
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	QDRRs are completed quarterly by the pharmacist.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	89% 8/9	2/2	0/1	2/2	2/2	N/A	N/A	2/2	N/A	N/A
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 8/8	N/A	N/A	2/2	2/2	N/A	N/A	2/2	2/2	N/A
	v. Anticholinergic burden.	78% 14/18	2/2	2/2	2/2	2/2	0/2	0/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:										
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.	100% 10/10	N/A	2/2	2/2	2/2	N/A	N/A	2/2	2/2	N/A
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	67% 8/12	0/1	1/1	1/1	1/2	1/1	2/2	0/1	1/2	1/1
e.	If an intervention indicates the need for a change in order and the prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.	N/R									
Comments: a. It was positive that the Clinical Pharmacist completed QDRRs timely for the individuals reviewed.											

b. The following summarizes the problems noted:

- For Individual #74, the quarterly medical summary documented that on 3/4/16, the individual received Ativan for pre-treatment sedation, but the QDRR did not record this use of a benzodiazepine.
- For Individual #71 and Individual #169, the QDRRs did not include comments about anticholinergic burden. The Pharmacist should have made a determination as to whether the burden was low, medium, or high, and documented the finding. If there was none, then the Pharmacist should have indicated a statement to that effect (e.g., none, 0, or low) to show that the Pharmacist reviewed this area of risk.

c. and d. For the individuals reviewed, it was good to see that prescribers were reviewing QDRRs timely, and documenting agreement or providing a clinical justification for lack of agreement with Pharmacy's recommendations. The following problems were noted for some of the individuals with regard to the implementation of agreed-upon recommendations:

- For Individual #45, the PCP agreed to a number of recommendations that were not implemented.
- For Individual #81, a recommendation to repeat an EKG was ordered, but there was no record an EKG was completed.
- For Individual #72, the Pharmacist made a recommendation for the PCP to evaluate the individual's constipation regimen due to the increased use of suppositories, but there was no evidence the PCP completed such an evaluation. The PCP did not address the recommendation after signing the QDRR on 2/8/16. On 2/23/16, another PCP saw the individual in the clinic due to rectal bleeding. At that time (14 days later), the PCP wrote to increase fiber and water and refer to gastroenterology (GI) for evaluation of external hemorrhoids.
- The 12/11/15 QDRR for Individual #10 recommended the completion of an overdue eye exam, but it was not completed until 2/22/16. In its response to the draft report, the State indicated: "Reference document TX-EP-1607-II-9, page 2, order for annual visual exam written by physician on 1/21/16. Reference document TX-EP-1607-II-64, page 2, individual had visual exam performed on 2/22/16… Gap in referral and exam due to death of previous ophthalmology consultant…" On 2/22/16, an eye exam was completed. However, what the State did not explain in its comments was that in the QDRR, dated 3/18/16, the Clinical Pharmacist specifically stated in the recommendation section that the last eye exam was done on 10/15/14. Therefore, the Clinical Pharmacist used incorrect data. Based on the information the State provided, the eye exam was done before the second QDRR, but not in response to the 12/11/15 QDRR (i.e., the physician did not write the order until over a month later). The outcome was that Individual #10, who had diabetes, had an eye exam that was overdue by four months.

Dental

Outcome 1 – Individuals with high or medium dental risk ratings show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant dental outcomes. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant	0%	0/1	N/A	0/1	0/1	0/1	0/1	N/A	N/A	0/1

	and achievable to measure the efficacy of interventions;	0/6									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	67% 4/6	1/1		0/1	1/1	0/1	1/1			1/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/6	0/1		0/1	0/1	0/1	0/1			0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6	0/1		0/1	0/1	0/1	0/1			0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6	0/1		0/1	0/1	0/1	0/1			0/1

Comments: a. and b. Individual #74, Individual #72, and Individual #10 were edentulous, and, therefore, at low risk for dental issues. The Monitoring Team reviewed the remaining six individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental. Although the dental goals/objectives for Individual #45, Individual #81, Individual #169, and Individual #70 were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, progress reports on existing goals, including data and analysis of the data, were not available to IDTs in 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. Individual #72, and Individual #10, and Individual #74 were in the core group, so full reviews were conducted for them. For the remaining six individuals, the Monitoring Team also conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.

Summary: These are new indicators, which the Monitoring Team will continue to review.

#	Indicator	Overall Score	Individuals: 45	74	140	81	71	169	72	10	70
a.	Individuals have no diagnosed or untreated dental caries.	50% 3/6	0/1	N/A	1/1	1/1	1/1	0/1	N/A	N/A	0/1
b.	Since the last exam:										
	i. If the individual had gingivitis (i.e., the mildest form of periodontal disease), improvement occurred, or the disease did not worsen.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. If the individual had a more severe form of periodontitis, improvement occurred or the disease did not worsen.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score	N/R									

	was maintained or improved.										

Comments: a. Individual #74, Individual #72, and Individual #10 were edentulous. Individual #45 had not had x-rays since 2014. Individual #70 had not had a comprehensive exam since 2014. Individual #169 had not had x-rays since 7/24/14.

b. Although six individuals reviewed had gingivitis or a more severe form of periodontitis, because serial periodontal probing had not occurred (i.e., annually), sufficient data was not available to determine whether or not improvement occurred or the disease had not worsened.

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Given that over the last two review periods and during this review, individuals and/or their staff generally received tooth-brushing instruction from Dental Department staff at preventative visits (Round 9 – 100%, Round 10 – 78%, and Round 11 - 100%), Indicator b will move to the category of requiring less oversight. The Facility needs to focus on the provision and quality of other dental treatment.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	33% 2/6	1/1	N/A	0/1	0/1	1/1	0/1	N/A	N/A	0/1
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 6/6	1/1	N/A	1/1	1/1	1/1	1/1	N/A	N/A	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	50% 3/6	0/1	N/A	1/1	1/1	1/1	0/1	N/A	N/A	0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/6	0/1	N/A	0/1	0/1	0/1	0/1	N/A	N/A	0/1
e.	If the individual has periodontal disease, the individual has a treatment plan that meets his/her needs, and the plan is implemented.	50% 3/6	1/1	N/A	0/1	1/1	1/1	0/1	N/A	N/A	0/1
f.	If the individual has need for restorative work, it is completed in a	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
	timely manner.										
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Comments: a. through g. Individual #74, Individual #72, and Individual #10 were edentulous.										

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
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. In the six months prior to the review, none of the individuals reviewed had reported dental emergencies.										

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: The Center had made progress with including measurable strategies in ISPs for suction tooth brushing for individuals who needed it, implementing the strategies, and monitoring the plans. However, over the last two reviews, results were variable. If the progress seen during this review continues, likely during the next review, one or more of these indicators might move to requiring less oversight. The Center does need to focus on QIDP monthly reviews including specific data and analysis of data related to suction tooth brushing, as appropriate.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 2/2					1/1				1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 2/2					1/1				1/1
d.	At least monthly, the individual's ISP monthly review includes specific	0%					0/1				0/1

	data reflective of the measurable goal/objective related to suction tooth brushing.	0/2									
Comments: None.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Improvements are needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	44% 4/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	0/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: For the individuals reviewed with missing teeth, the Dental Department often did not provide clinically justified recommendations regarding dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained an area on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	45% 5/11	1/1	0/1	0/2	0/1	N/A	N/A	1/2	2/2	1/2
b.	For an individual with an acute illness/occurrence, licensed nursing	27%	0/1	0/1	0/2	0/1			0/2	2/2	1/2

	staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	3/11									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	29% 2/7	0/1	N/A	1/1	0/1			0/2	1/1	0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	25% 1/4	N/A	0/1	0/1	N/A			N/A	1/1	0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/11	0/1	0/1	0/2	0/1			0/2	0/2	0/2
f.	The individual's acute care plan is implemented.	0% 0/11	0/1	0/1	0/2	0/1			0/2	0/2	0/2

Comments: The Monitoring Team reviewed 11 acute illnesses and/or acute occurrences for seven individuals, including Individual #45 – dysuria, urinalysis and culture on 3/15/16; Individual #74 – facial trauma on 5/21/16; Individual #140 – hypoxia and altered mental status on 12/10/15, and lacerations to fourth finger of left hand on 5/11/16; Individual #81 – excoriation left ear, helix, and canker sore in mouth on 2/16/16; Individual #72 – upper respiratory infection on 4/1/16, and foul smelling urine on 5/7/16 with urinary tract infection diagnosed on 5/27/16; Individual #10 – chronic diarrhea, altered mental status, hypo-magnesium, hypophosphatemia, and acute respiratory failure on 12/15/15, and pneumonia on 5/1/16; and Individual #70 – hypotension, acute gastritis, and febrile illness on 2/9/16, and coccyx pressure ulcer on 4/6/16.

a. The acute illness/occurrence for which licensed nursing staff performed nursing assessments when the individual displayed signs or symptoms were those for: Individual #45 – dysuria, urinalysis and culture on 3/15/16; Individual #72 – upper respiratory infection on 4/1/16; Individual #10 – chronic diarrhea, altered mental status, hypo-magnesium, hypophosphatemia, and acute respiratory failure on 12/15/15, and pneumonia on 5/1/16; and Individual #70 – hypotension, acute gastritis, and febrile illness on 2/9/16.

b. The acute illnesses/occurrences for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms were: Individual #10 – chronic diarrhea, altered mental status, hypo-magnesium, hypophosphatemia, and acute respiratory failure on 12/15/15, and pneumonia on 5/1/16; and Individual #70 – hypotension, acute gastritis, and febrile illness on 2/9/16.

c. For the following individuals with an acute illness/occurrence that was treated at the Facility, licensed nursing staff conducted ongoing nursing assessments: Individual #140 – lacerations to fourth finger of left hand on 5/11/16, and Individual #10 – pneumonia on 5/1/16.

d. For the following individual with an acute illness/occurrence that required hospitalization, licensed nursing staff conducted pre- and post-hospitalization assessments: Individual #10 – chronic diarrhea, altered mental status, hypo-magnesium, hypophosphatemia, and acute respiratory failure on 12/15/15.

e. In some cases, acute care plans should have been developed, but were not. Common problems with the acute care plans reviewed

included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; alignment with nursing protocols; specific goals that were clinically relevant, attainable, and realistic to measure the efficacy of interventions; clinical indicators nursing would measure; and the frequency with which monitoring should occur.

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

- For Individual #74's facial trauma on 5/21/16, a nursing IPN indicated he was placed on the head injury protocol. However, no initial or ongoing neurological checks or neurological check sheets were found. Prior to the ED visit, no documentation was found to show the nurse communicated with the PCP. The only notation was that the individual was referred to the clinic. After the ED visit, IPNs documented the nurse's successive attempts to contact the PCP with "no answer." An acute care plan was not developed and/or implemented.
- For Individual #81's excoriation of his left ear, helix, and canker sore in his mouth on 2/16/16, ongoing nursing assessments regarding the skin integrity issue with his left ear did not include whether or not the size of the excoriation was increasing or decreasing, changes in color, and/or description of whether or not there was drainage. An acute care plan was not found for the time of the initial onset of the skin integrity issues. The acute care plan developed at the time of the incision and drainage of the ear did not define individualized criteria for assessing pain, nor did it describe expectations regarding observations of the site(s), including frequency. Infection control practice guidelines in the acute care plan were insufficient.
- On a positive note, on 12/15/15, nursing staff recognized a change in status for Individual #10 that constituted an emergency and initiated a 911 call. More specifically, while waiting for non-emergency transportation due to a lab finding, Individual #10's respiratory status changed, and the nurse called 911. However, upon the individual's return to El Paso SSLC, the acute care plan developed did not meet the individual's needs.
- Similarly, on 5/1/16, nursing staff initiated a call to 911 when Individual #10 experienced critical oxygen saturation rates. Attempts to contact the practitioner were documented, but nursing documentation did not show the response from the physician. The individual was diagnosed with pneumonia, but no acute care plan was found.
- On 3/23/16, the PNMT nurse documented Individual #70 had a Stage I hospital-acquired decubitus ulcer to his left hip and sacrum that was 5 millimeters by 4 millimeters. A medical note on the same date indicated the ulcer was healed. However, on 3/29/16, an order was noted to change the dressing to the left hip and sacrum daily, and as needed. On 3/29/16, a nursing note indicated the nurse changed the dressing. The next nursing note regarding the sacrum area was dated 4/6/16. On 4/7/16, a medical IPN documented a diagnosis of Coccyx Pressure Ulcer Stage I and Stage II. No measurements were provided. For this individual, nursing staff should have conducted frequent post-hospitalization skin assessments, including, for example, measurements of the ulcer, but such assessments were not documented. As has been recommended in the past, nursing staff should have training from an outside certified wound/ostomy nurse to understand pressure ulcers and skin integrity, and the importance of documenting width, length, and depth on a consistent basis. Moreover, a post-hospitalization acute care plan was not found for Individual #70. Although the following acute care plans were found, none of them were signed with dates, and none of them had revision or resolved dates: Hydrocephalus, dated 4/13/16, and status-post percutaneous endoscopic gastrostomy tube (PEG-tube) placement, baseline data date of 3/22/16, with implementation date documented as 8/22/16.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.	
Summary: For individuals reviewed, IDTs did not have a way to measure outcomes	Individuals:

related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.											
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal/objective to measure the efficacy of interventions.	28% 5/18	0/2	2/2	1/2	0/2	1/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #45 – constipation/bowel obstruction, and urinary tract infections (UTIs); Individual #74 – weight, and UTIs; Individual #140 – gastrointestinal problems, and seizures; Individual #81 – infections, and other: pain; Individual #71 – hypothermia, and other: elevated intraocular pressure; Individual #169 – gastrointestinal problems, and seizures; Individual #72 – respiratory compromise, and constipation/bowel obstruction; Individual #10 – respiratory compromise, and infections; and Individual #70 – respiratory compromise, and skin integrity).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: Individual #74 – weight, and UTIs; Individual #140 – seizures; Individual #71 – other: elevated intraocular pressure; and Individual #10 – infections.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
Summary: Given that over the last three review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70

a.	The nursing interventions in the individual's ISP/IHCP that meet their needs are implemented beginning within fourteen days of finalization or sooner depending on clinical need	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	0% 0/9	N/A	N/A	0/1	0/2	N/A	0/1	0/1	0/2	0/2
c.	The individual's nursing interventions are implemented thoroughly as evidenced by specific data reflective of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

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

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

The following provide some examples of concerns related to this Outcome:

- On 1/19/16, Individual #81 had mandibular fixation hardware removed from his jaw. The Medication Administration Records (MARs) beginning on 2/11/16 indicated nursing staff administered multiple doses of pain medication. The IDT should have held an ISPA meeting to discuss his pain and ways to manage it.
- Beginning in December 2015, Individual #140 had increased seizure activity that reportedly impacted her functional motor skills. On approximately 12/10/15, she was diagnosed with aspiration pneumonia. On 4/20/16, the PNMT discharged her, and a note indicated: "IDT to mitigate risk of aspiration by monitoring seizure activity to identify risks or trends and address causes that may be exacerbating seizures." No additional ISPAs were found to show that the IDT reviewed seizure activity as recommended.
- For Individual #169, the Comprehensive Nursing Assessment documented her last seizure as having occurred in September 2015. She had a seizure on 5/15/16. Given the time since the last seizure, nursing staff should have notified the physician about the seizure. In addition, the IDT should have met to review her seizure risk.
- For Individual #10, the MAR indicated that the oxygen machine was at the bedside for as-needed use when the individual's oxygen saturation rates were less than 90%. However, nursing staff had not regularly documented oxygen saturation rates.

Outcome 6 – Individuals receive medications prescribed in a safe manner.	
Summary: For the two previous reviews, as well as this review, the Center did well with the indicators related to administering medications according to the nine rights (c), and nurses following the PNMP during medication administration (f, and previously e). However, given the importance of these indicators to individuals'	Individuals:

health and safety and the fact that the most basic cause of the majority of the medication variances was that nurses were not following the nine rights of medication administration, the Monitoring Team will continue to review them until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.											
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual receives prescribed medications in accordance with applicable standards of care.	50% 7/14	0/1	1/1	1/2	1/2	0/1	2/2	0/1	1/2	1/2
b.	Medications that are not administered or the individual does not accept are explained.	22% 2/9	0/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1	0/1
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% 5/5	N/A	N/A	1/1	1/1	N/A	1/1	N/A	1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	Not rated (N/R)									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	N/R									
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	0% 0/8	0/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1	0/1

f.	Individual's PNMP plan is followed during medication administration.	100% 4/4	N/A	N/A	1/1	1/1	N/A	N/A	N/A	1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	80% 4/5	N/A	N/A	1/1	1/1	N/A	0/1	N/A	1/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	13% 1/8	0/1	1/1	0/1	0/1	0/1	N/A	0/1	0/1	0/1
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A

Comments: The Monitoring Team conducted record reviews for nine individuals and observations of five individuals, including Individual #45 (no observation), Individual #74 (no observation), Individual #140, Individual #81, Individual #71 (hospitalized, so no observation), Individual #169, Individual #72 (deceased so no observation), Individual #10, and Individual #70.

a. and b. Problems noted included:

- The Medication Administration Records (MARs) for Individual #45, Individual #140, Individual #81, Individual #71, Individual #72, Individual #10, and Individual #70 showed numerous omissions and/or MAR blanks for which variance forms were not provided.
- Applicable standards of care require that nurses document the site an injection is administered. This also serves to ensure site rotation. For Individual #10, injection sites were not noted on the MAR, or Nursing IPNs provided. This information might be on a Diabetic sheet the Facility has, however, it was not provided in response to the document request.

c. It was positive to see that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration.

d. This indicator was not assessed during this review, but will be during upcoming reviews. State Office is working with the Centers to comply with these requirements.

e. At times, nursing staff did not document the reason, route, and/or the individual's reaction or the effectiveness of the PRN or STAT

medication.

f. During onsite observations, it was positive that nursing staff followed the PNMPs for four individuals.

g. With one exception, for the individuals observed, nursing staff followed infection control practices. The exception was for Individual #169, for whom hand hygiene was not performed to standards, and glove contamination occurred (i.e., touching objects such as the door knob prior to the application of medication).

h. For the records reviewed, evidence was not present to show that nursing staff provided instructions to the individuals and their staff regarding new orders or when orders changed.

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

j. and k. For the individuals reviewed, Facility staff did not identify any possible ADRs.

l. The problems related to documentation of medication variances varied, but some examples included:

- MAR blanks were not reconciled and reported;
- Some of the variance forms reviewed were incomplete. For example, at times, details were missing, the supervisory response was missing, and/or the descriptions of follow-up were left blank;
- Lack of identification of variances (i.e., the Monitoring Team identified some variances the Center had not identified); and
- At times, variances were classified as documentation issues, but it was unclear if the individual received his/her medication. For example, for Individual #10's insulin, a Medication Variance Report noted the date of a variance as 2/8/16, and noted it was discovered on 2/17/16. The Medication Variance report was dated 2/19/16. It could not be discerned from the documentation provided whether or not the individual actually received his insulin or how Facility staff determined this to be the case, but the variance was noted as missing documentation.

As was indicated in the last report and the Monitoring Teams discussed in detail with the Chief Nurse Executive (CNE), an overall issue that was noted with the MARs was related to the lack of continuity of the time periods MARs covered. Often, this appeared to be a function of a new medication being added in the middle of the MAR cycle. A new MAR would be started with the new medication added and the previous medications listed, but nursing staff would not mark through the remaining dates on the old MAR with a notation that the new MAR should be used. This practice was wrought with potential for medication variances. As discussed with the CNE, when a new medication is ordered and the pharmacy prints a new MAR or when nursing staff transcribe a new medication, the previous MAR should not be left with multiple blanks for the same administration period, but rather should have unused dates marked through. It was concerning that Center staff had not addressed this issue since the Monitoring Team's last review.

m. For Individual #81, on 3/3/16, a nurse administered the wrong dose of Ibuprofen. A physician's order indicated that the evening dose should not be given. However, no documentation was found to show that this order was communicated through an IPN or the MAR.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see that for the individuals reviewed referrals were made to the PNMT, as appropriate. This was an improvement from the last review, when 67% of individuals were appropriately referred. Overall, though, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individuals with PNM issues for which IDTs have been responsible show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	7% 1/15	0/2	0/2	0/1	0/2	0/2	0/2	1/2	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	47% 7/15	1/2	0/2	1/1	0/2	2/2	1/2	0/2	1/1	1/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/15	0/2	0/2	0/1	0/2	0/2	0/2	0/2	0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	100% 4/4	N/A	N/A	1/1	N/A	N/A	N/A	N/A	1/1	2/2
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	25% 1/4			0/1					1/1	0/2
	iii. Individual has a measurable goal/objective, including	0%			0/1					0/1	0/2

		timeframes for completion;	0/4									
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/4			0/1					0/1	0/2
	v.	Individual has made progress on his/her goal/objective; and	0% 0/4			0/1					0/1	0/2
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4			0/1					0/1	0/2

Comments: The Monitoring Team reviewed 15 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: falls, and choking for Individual #45; choking, and falls for Individual #74; falls for Individual #140; choking, and weight for Individual #81; aspiration, and fractures for Individual #71; choking, and fractures for Individual #169; aspiration, and falls for Individual #72; falls for Individual #10; and weight for Individual #70.

a.i. and a.ii. The IHCP that included a clinically relevant, and achievable goal/objective was the one for falls for Individual #72. Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individuals' progress or lack thereof: falls for Individual #45; falls for Individual #140; aspiration, and fractures for Individual #71; fractures for Individual #169; falls for Individual #10; and weight for Individual #70.

b.i. The Monitoring Team reviewed four areas of need for three individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration for Individual #140; aspiration for Individual #10; and aspiration, and weight for Individual #70. It was positive that these individuals were referred to the PNMT.

b.ii. and b.iii. Working in conjunction with Individual #10's IDT, the PNMT developed clinically relevant, and achievable goals/objectives for aspiration.

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

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

Summary: These indicators will remain in active oversight.

#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated	11% 2/18	0/2	0/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2

	ISP progress reports provide an explanation for any delays and a plan for completing the action steps.										
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	50% 3/6	N/A	0/1	1/1	N/A	1/1	N/A	N/A	1/1	0/2
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% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. However, the IHCPs for which documentation was found to confirm the implementation of the PNM action steps that were included were those for choking for Individual #169, and falls for Individual #72. Often, it was difficult to measure completion, because timeframes for completion were listed as "ongoing."

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

- For Individual #74, no evidence was found to show the IDT met after his fracture in May 2016.
- Individual #140 and Individual #10's IDTs appropriately referred them to the PNMT with regard to their aspiration risk.
- On 4/13/16, Individual #71 was hospitalized, and as of the time of the onsite review, he had not returned to EPSSLC. According to an ISPA dated 5/10/16, although he had been on hospice with DNR status, he was expected to return to EPSSLC with full code status reinstated. The PNMT continued to routinely review his status.
- Although Individual #70's IDT referred him to the PNMT for weight and aspiration, no change of status ISPA meeting was documented as having been held.

c. For Individual #140, although a discharge ISPA was held on 4/27/16, there was no evidence of an update to the IHCP or specific outline of actions for transfer to IDT.

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

Summary: No improvement was noted with regard to the Center's performance on these indicators. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

#	Indicator	Overall Score
a.	Individuals' PNMPs are implemented as written.	61% 31/51
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic	50% 2/4

	rationale/reason for the PNMP.	
Comments: a. The Monitoring Team conducted 51 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during eight out of twelve observations (67%). Staff followed individuals' dining plans during 22 out of 35 mealtime observations (63%). Staff completed transfers correctly in one out of four observations (25%).		

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: The Center had not made progress on this indicator.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/3	N/A	N/A	N/A	N/A	0/1	N/A	N/A	0/1	0/1
Comments: a. As noted above, for Individual #71, Individual #10, and Individual #70, based on review of their PNMPs, it was not clear whether or not they received some oral intake, and if so, if there was a plan to move them along the continuum of oral intake, as appropriate to their needs.											

OT/PT

Outcome 1 – Individuals with formal OT/PT services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: It was good to see that some OT/PT goals/objectives developed for individuals reviewed were clinically relevant, and measurable. However, for individuals reviewed, IDTs overall did not have a way to measure outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	38% 5/13	0/1	N/A	3/4	0/1	N/A	N/A	1/1	0/3	1/3
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	23% 3/13	0/1	N/A	3/4	0/1	N/A	N/A	0/1	0/3	0/3
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/13	0/1	N/A	0/4	0/1	N/A	N/A	0/1	0/3	0/3
d.	Individual has made progress on his/her OT/PT goal.	0%	0/1	N/A	0/4	0/1	N/A	N/A	0/1	0/3	0/3

		0/13									
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/13	0/1	N/A	0/4	0/1	N/A	N/A	0/1	0/3	0/3

Comments: a. and b. Individual #74 had functional motor and self-help skills, so goals/objectives were not indicated. Individual #71 did not have OT/PT goals/objectives recommended, and this seemed appropriate based on assessment information. Individual #169 was receiving indirect PT supports through a service objective, which appeared appropriate.

The goals/objectives that were clinically relevant and achievable, as well as measurable were those for Individual #140 related to standing transfers, ambulating 50 feet, and ambulating 300 feet. The IDT approved them during an ISPA meeting. Although the therapist maintained data on their implementation in IPNs, this information was not summarized or analyzed in the ISP monthly reviews. Similarly, Individual #72 had a clinically relevant goal. It was not measurable, and although some PT progress notes were available, the QIDP ISP monthly reviews reported no related data, but said he walked in the gait trainer every day. The sitting balance goal for Individual #70 was clinically relevant, but not measurable.

c. through e. As a result of the lack of clinically relevant and/or measurable goals/objectives, as well as a lack of progress reports summarizing and analyzing data, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. As noted above, unfortunately, in some cases, it appeared therapists maintained data, but this information was not incorporated into integrated ISP progress reports.

Individual #74 was part of the core group, and so the Monitoring Team conducted full monitoring of his supports and services. Individual #71 did not require OT/PT goals/objectives, but did require other OT/PT supports (e.g., assessment, indirect supports related to vision impairment, etc.) As a result, a full review of his services was conducted. Similarly, Individual #169 was receiving indirect PT supports through a service objective, and so a full review of her services was conducted. For the remaining six individuals, full reviews were conducted due to a lack of clinically relevant, achievable, and measurable goals/objectives to address areas of OT/PT need, and/or because integrated ISP progress reports did not provide an analysis of related data.

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

Summary: It was good to see significant improvement from the last review with the Center's scores for these indicators (i.e., 11% for a, and 0% for b). The Monitoring Team will continue to review them.

			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	78% 7/9	1/1	N/A	1/2	N/A	N/A	N/A	2/2	1/1	2/3
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP	67% 4/6	1/1	N/A	1/2	N/A	N/A	N/A	2/2	0/1	N/A

	meeting, then an ISPA meeting is held to discuss and approve the change.									

Comments: a. and b. Some examples of the problems noted included:

- Evidence was not submitted to substantiate that Individual #140's direct PT goal was implemented. Moreover, the Monitoring Team requested 12 months of IPNs to have the information to make findings related to implementation as well as termination of OT/PT services. The Facility did not provide the requested documents.
- No ISPA was submitted to show the IDT discussed Individual #10's discharge from PT services on 2/9/16.
- For Individual #70's walking program, the data sheet submitted recorded "N" for most days, indicating it was not completed.

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

Summary: Given that over the last two review periods and during this review, individuals observed generally had clean adaptive equipment (Round 9 – 95%, Round 10 – 100%, and Round 11 - 100%) that was in working order (Round 9 – 100%, Round 10 – 100%, and Round 11 - 100%), Indicators a and b will move to the category of requiring less oversight. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 100%, Round 10 – 70%, and Round 11 - 79%), this indicator will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators.

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

			Individuals:								
#	Indicator	Overall Score	93	127	117	129	113	70	21	187	179
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	100% 14/14	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.	100% 14/14	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	79% 11/14	0/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		90	16	103	92	107				

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

Comments: a. The Monitoring Team conducted observations of 14 pieces of adaptive equipment. The individuals the Monitoring Team observed had clean adaptive equipment, which was good to see.

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

c. Based on observation of Individual #93, Individual #70, and Individual #90 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors.

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

This domain contains 12 outcomes and 38 underlying indicators in the areas of ISP implementation, skill acquisition. One of these, regarding the facility's collaboration with the local public school district, had sustained high performance scores and will be moved the category of requiring less oversight.

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

Given that ISPs did not yet contain personal goals and action plans that met the various criteria, the indicators related to progress were also not met. For example, for individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals or the outcomes of skill acquisition plans. Similarly, goals/objectives related to communication for the individuals reviewed were largely not clinically relevant and/or measurable.

Skill acquisition plans existed for each individual, but they were inadequate in terms of content, implementation quality, and review.

Some improvement was noted with regard to individuals having access to and using AAC/EC devices functionally. Given the overall low scores from previous reviews, this was good to see.

Some individuals were regularly engaged in activities, but many were not. The facility had a reasonable system for measuring engagement in activities, and had set reasonable goals, but these were not yet met.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that goals were not yet individualized and did not meet criterion with ISP indicators 1-3, the indicators of this outcome also did not meet criteria. The handful of goals that were developed were not implemented and/or not reviewed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	142	74	26	45	70	10			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

#	Indicator	Overall Score									
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. For the goals that met criterion with Outcome 1 Indicator 1 in Domain 2, scoring was negatively impacted because the QIDP monthly review process had been suspended making a review of data to determine progress or regression unavailable to the IDTs. The monthly review process was implemented again in April 2016, however, even so, not all supports were reviewed and little data were available to determine status on outcomes. SAP data were inconsistent for most goals.

See Outcome 7, Indicator 37 for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans.

Outcome 8 – ISPs are implemented correctly and as often as required.

Summary: These indicators will remain in active monitoring.

#	Indicator	Overall Score	142	74	26	45	70	10			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39-40. Documentation indicated that action steps were not consistently implemented as noted in examples throughout this report. For the most part, observations and staff interviews supported that staff were familiar with individual's ISPs and action plans. This was good to see. Due to lack of consistent implementation, however, it was difficult to assess staff competency.

Skill Acquisition and Engagement

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.

Summary: Determining whether SAPs are progressing and taking actions to develop new SAPs or to modify existing SAPs was not occurring at El Paso SSLC. This outcome and its indicators will continue to receive active monitoring.

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166

6	The individual is progressing on his/her SAPS	0% 0/15	0/2	0/1	N/A	1/2	0/2	0/3	1/2	0/2	0/1
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	If the individual was not making progress, actions were taken.	0% 0/5	N/A	0/1	N/A	N/A	N/A	N/A	0/2	0/2	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	0% 0/5	N/A	0/1	N/A	N/A	N/A	N/A	0/2	0/2	N/A

Comments:
6. No individual had reliable data indicating he or she was making progress. There was insufficient data to determine progress for Individual #142's state time SAP and Individual #171's count coins SAP. Individual #114 appeared to be progressing in his play catch SAP, however, the data were not demonstrated to be reliable (see indicator #5), so this SAP was not scored as progressing. Several SAPs had insufficient data to determine progress, however, were scored as zero because the data were not demonstrated to be reliable (e.g., Individual #166 's SAP to make a smoothie).

8-9. Individual #45's place cup and use her cloth hamper, Individual #83's call family and put clothes in the hamper, and Individual #142's set the water temperature SAPs were not making expected progress, however, there was no evidence of actions to address the absence of progress, and no evidence of data based decisions to continue, discontinue, or modify SAPs.

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

Summary: SAPs were missing many components; none had all of the required components, including the absence of clear training instructions. This will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 13	142	171	74	26	114	83	45	166
13	The individual's SAPs are complete.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/3	0/2	0/2	0/1

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the 17 SAPs were judged to be complete. A common missing component was the absence of clear SAP training instructions. All SAPs indicated that they utilized forward chaining, backward chaining, or total task training procedures. None of the SAPs, however, described how to implement these training methodologies. Further, none of the DSPs implementing the SAPs or interviewed by the Monitoring Team understood the differences associated with these different training procedures.

Another common missing component was a task analysis. Many of the task analyses contained staff behavior and only one individual behavior (e.g., Individual #45's use the cloth hamper SAP). Additionally, the majority of SAPs that utilized total task training suggested recording the prompt level rather than the number of sessions completed at the goal prompt level (e.g., Individual #166's make a

smoothie SAP).

Improving the quality of the SAPs should be a priority for the facility.

Outcome 5- SAPs are implemented with integrity.											
Summary: SAPs that were observed by the Monitoring Team were not done correctly and the facility had not implemented a plan to regularly assess the quality of implementation. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
14	SAPs are implemented as written.	0% 0/2	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/3	0/2	0/2	0/1

Comments:

14. The Monitoring Team observed the implementation of two SAPs. The DSPs implementing Individual #171's count coins SAP, and Individual #142's state the time SAP did not use the correct training steps/methodology contained in the SAP.

15. El Paso SSLC established that SAP integrity assessments would occur for each SAP monthly. None of the SAPs had monthly integrity measures. Two SAPs (Individual #74's pour drink and Individual #83's call family) had integrity assessments in the last six months. The remaining SAPs had no evidence of integrity assessments. The only way to ensure that SAPs are implemented as written is to conduct regular 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.

SAP data are reviewed monthly, and data are graphed.											
Summary: Many SAPs were reviewed, but only about half met criteria. The graphing summaries of SAP performance were inadequate. Both of these indicators will continue to receive active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
16	There is evidence that SAPs are reviewed monthly.	58% 10/17	2/2	0/2	0/1	1/2	0/2	2/3	2/2	2/2	1/1
17	SAP outcomes are graphed.	0% 0/17	0/2	0/2	0/1	0/2	0/2	0/3	0/2	0/2	0/1

Comments:
16. The majority of SAPs were reviewed in QIDP monthly reports and included a data based review. Some SAPs, however, were not reviewed (e.g., Individual #142's state the time SAP), others were reviewed, but SAP data were not present (e.g., Individual #74's operate his M3P player SAP), and others appeared to have data that were inconsistent with the SAP training sheet or SAP raw data (e.g., Individual #26's organize his personal items SAP).

17. There was evidence that some SAPs were graphed, however, they were not graphed in a way that allowed one to visually assess trends.

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

Summary: It was good to see that El Paso SSLC measured engagement and had goals for engagement. Goals, however, were not achieved and observations by the Monitoring Team found less than half of the individuals to be engaged in activities. This outcome and its indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	0/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The day and treatment sites of the individual have goal engagement level scores.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
18-21. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found four (Individual #83, Individual #166, Individual #26, Individual #142) of the nine individuals (44%) consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). El Paso SSLC conducted monthly engagement measures in all residential and day programming sites. Their established goal was 65% engagement (using a momentary sampling system to rate engagement that is similar to that used by the Monitoring Team).

The facility's engagement data indicated that none of the residential and day treatment sites of the individuals achieved their engagement goals. The Monitoring Team found the monitoring system used by the facility to be a sensitive measure of individual engagement. Finally, although one would not expect 1:1 correspondence between the facility's engagement ratings and those of the Monitoring Team because the facility was measuring sites (i.e., residences, day programs) and the Monitoring Team was measuring individual engagement, the Monitoring Team found the facility ratings to be generally consistent with their observations of individual engagement.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings occurred, but did not meet criteria for this indicator. SAP training in the community was not occurring. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	13	142	171	74	26	114	83	45	166
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: 22-23. 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. EPSSLC did not provide data concerning the implementation of SAPs in the community. 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.											

Outcome 9 – Students receive educational services and these services are integrated into the ISP.											
Summary: El Paso SSLC had one individual who attended school. The facility had a good working relationship with the El Paso school district. The requirements for this indicator have been met for many years and this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	171								
25	The student receives educational services that are integrated with the ISP.	100% 1/1	1/1								
Comments: Individual #171 was under age 22 and attending public school at the time of the onsite review. He received educational services that were integrated into his ISP.											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/1	N/A	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/1					0/1				
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/1					0/1				
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/1					0/1				
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/1					0/1				
Comments: Individual #71's IDT had not developed a plan and/or goal/objective to address his dental refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: The Center had made no progress on these indicators. They will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	20% 2/10	0/1	0/1	1/1	0/1	1/2	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/10	0/1	0/1	0/1	0/1	0/2	0/1	0/1	0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the	0%	0/1	0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1

	measurable goal(s)/objective(s).	0/7									
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/7	0/1	0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	N/A	N/A	0/1	0/1	0/1

Comments: a. and b. The goals/objectives that were clinically relevant, but not measurable were Individual #140's goal/objective to choose clothing, and Individual #71's goal/objective related to his Environmental Control device for his TV. Individual #71 was hospitalized shortly after his annual ISP meeting, and had not yet returned to the Center.

c. For the nine individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives, and/or a lack of IDT analysis and/or action when progress did not occur.

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

Summary: Implementation of communication programs continued to need improvement.

#	Indicator	Overall Score	45	74	140	81	71	169	72	10	70
			Individuals:								
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	25% 1/4	0/1	0/1	0/1	N/A	N/A	1/1	N/A	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. The Monitoring Team reviewed the ISP integrated reviews (as indicated in the audit tool) to determine whether or not the measurable strategies related to communication were implemented. Evidence was not present to show that the strategies were implemented.

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

Summary: Some improvement was noted with the Center's performance with these indicators. Given the overall low scores from previous reviews, this was good to see. The Center is encouraged to continue to focus on ensuring individuals' AAC/EC devices are available in all appropriate settings, and individuals use them functionally.

#	Indicator	Overall	86	92	114	9	188	80			
			Individuals:								

		Score									
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	83% 5/6	1/1	1/1	0/1	1/1	1/1	1/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	67% 4/6	1/1	1/1	0/1	1/1	1/1	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	86% 6/7									
Comments: None.											

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

This domain contains five outcomes and 20 underlying indicators. Good progress has been made as evidenced by five of the 20 indicators now requiring less oversight. All five of these are part of outcome #2, related to post move monitoring. Some aspects of this outcome, however, will require continued focus, specifically regarding individuals' receipt of supports. Outcome #1, related to the quality and comprehensiveness of the set of pre and post move supports continued to show improvement, too. Outcome #4, related to transition activities, showed good involvement of IDTs, LARs, and individuals, however, transition assessments need improvement, and some transition activities need to occur and be documented.

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

The admissions and placement department continued to be well organized and very active. Three individuals moved since the last review, which was less than 3% of the census. Thirteen individuals were on the referral list; which was more than 12% of the census. A problem was capacity in the community. Many of these individuals were ready for transition, but the community providers did not have vacancies, and/or did not have accessible housing. Some were developing new homes, but that takes time. Coincidentally, at the end of the onsite review week, the facility was notified that one provider had secured a new home and that this may set the occasion for three or four individuals to transition over the next six months or so.

The Admissions and Placement Coordinator and his staff continued to engage in many activities to support individuals' referral for transition. Examples included the semi-annual provider fair, tours of providers for individuals as well as for their families and various SSLC staff, participation in the El Paso SSLC ISP improvement committee, maintaining an accurate database of obstacles to referral for every individual at the facility, and attending ISP meetings to talk about community options.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.	
Summary: The CLDPs contained many pre and post move supports and many were individualized as required by this outcome. More work, however, needs to be done to write supports in a way that they are measurable, so that the IDT, provider, and PMM can determine if the support is being provided. Further, to ensure that the list of supports is comprehensive, the APC and his staff need to work with IDT members and thoroughly review documents (e.g., ISPs, transition assessments) to make recommendations for pre and post move supports, as needed. These two indicators	

will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	153	57							
1	The individual's CLDP contains supports that are measurable.	0% 0/2	0/1	0/1							
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/2	0/1	0/1							

Comments:
Three individuals transitioned from the facility to the community since the last monitoring review. Two were included in this review (Individual #153 May 2016, Individual #57 February 2016). Individual #153 transitioned to a foster living arrangement and Individual #57 transitioned to three-person group home. Both programs were part of the State's Home and Community-based Services program (HCS). Individual #153's placement failed and he returned to live at El Paso SSLC. Overall, Individual #57 was doing well in his new home and day program.

The Monitoring Team reviewed these two transitions and discussed them in detail with the Admissions and Placement Coordinator (APC), the Transition Specialist (TS), and the Post Move Monitor (PMM) while onsite.

1. Both individuals had more than 50 supports listed in the CLDP. Pre-move supports were primarily regarding training and orientation of provider staff. Every pre-move support was also included as a post-move support for implementation of those supports; this was good to see. The supports that met criterion were those that were worded in a way that the PMM (and the provider) could determine if the support was provided. Examples included brushing teeth four times per day, seeing the PCP and reviewing a list of specified medical conditions, and monitoring bowel movements.

The supports that did not meet criterion included the many related to staff training sessions for provider staff. The supports described the content, and who was to provide the training, but did not describe the method for teaching (e.g., didactic, role play, in vivo) and did not refer to how competency would be assessed (e.g., quiz, verbal report, demonstration). The CLDPs contained the same wording for all trainings, even though the type of training and competency assessment varied (or should vary). For example, El Paso SSLC's nursing staff demonstrated g-tube feedings for Individual #57 and then observed implementation by the provider staff for competency. Although this was mentioned in the CLDP deliberations, it should be included in the supports because that is what the PMM and provider focus upon.

The others that did not meet criterion included those about the provision of the quality of life supports. El Paso SSLC did a very nice job of creating four separate post move supports that focused on various aspects of the individual's preferences (i.e., community activities, home activities and personal time, foods, preferred items). Moreover, these were listed first, highlighting their importance. More detail, however, was needed regarding the frequency, variety, and location (home/day/work) of provision of each of the items within each of the four quality of life supports. Others that did meet criterion were implementation of the behavior plan and provide plenty of liquids.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion.

- Past history, and recent and current behavioral and psychiatric problems: Both did not meet criterion because no detail was provided regarding the important parts of the PBSP or PSP that needed to be implemented. Individual #57's did not include the especially important aspects of interaction style, such as not over-prompting him or prompting him from behind. For Individual #153, a more comprehensive set of supports regarding his psychiatric and behavioral supports should have been included. This likely contributed to his placement failing.
- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The CLDPs included numerous supports related to this area. This was good to see. To meet criterion, however, more detail should be provided. This includes reviewing the IRRF and updating it if necessary or indicating that it was reviewed and nothing new needed to be considered by the IDT regarding risk areas. Further, not all habilitation recommendations were carried forward or reviewed by the IDT. Some specific safety and health related topics were not addressed, such as CPAP machine for Individual #153, and details about implementation of the abdominal binder (e.g., checking it, changing it) or the hospital bed (percentage or angle) for Individual #57.
- What was important to the individual: A strength of this set of CLDPs was the focus on the individuals' preferences. The CLDPs contained four separate supports for this area. They were labeled as quality of life supports regarding food, personal items, activities, and personal time. This was very good to see. Criterion was met for both individuals.
- Need/desire for employment, and/or other meaningful day activities: There were no supports for Individual #153's day program or employment. His participation in day/work activities was likely one variable that contributed to his success while at El Paso SSLC and the absence of supports in this area may have contributed to the failure of his placement. Individual #57 also had no supports for day activities. He attended a day habilitation program, but there were no supports regarding his attendance, activities, or meaningful participation. The APC and his staff said that the four quality of life supports applied to the day program, too. These supports, however, did not indicate day program implementation. This can be a reasonable way of addressing day programming in the CLDP supports, but the supports must include details about which items and activities are going to occur in the day program versus the home, as well as the frequency, the variety, and so forth in each setting.
- Positive reinforcement, incentives, and/or other motivating components to an individual's success: Individual #153's behavioral health transition assessment specifically recommended a behavioral contract as well as other important aspects of his behavioral plan. These were not included in his CLDP supports. The APC directed the Monitoring Team to review the deliberations discussion in the ISP, which the Monitoring Team did again, but there was nothing describing the rationale for there not being these supports in place for Individual #153. Individual #57 did not have any specific motivational system, nor did he appear to need one. Given his supports included access to so many of his preferred activities, foods, and items, this indicator was scored as meeting criterion for him.
- Teaching, maintenance, participation, and acquisition of specific skills: Individual #57's CLDP contained supports for skill acquisition that were appropriate and related to his preferences and skill set. Individual #153 had a support for having skill programming for money management and cooking. Given Individual #153's preferences and abilities, this was inadequate for him, especially given that he reported that he wanted to learn to read and to take classes as El Paso Community College.
- All recommendations from assessments are included; or if not, there is a rationale provided: The assessment section of the CLDPs had a very good structure. That is, the assessment content and recommendations were provided, followed by a description of the IDT's discussion and deliberation, followed by the IDT's ultimate determination of recommendations to go on the list of supports. At El Paso SSLC, many recommendations in the transition assessments did not make it into the list of CLDP supports, and the deliberations paragraphs in the CLDPs did not include a rationale as to why not. This is an area for improvement in the facility's CLDPs. That is, there needs to be improvement in the discussion/deliberations paragraph to

	explain why recommendations were not carried forward into the list of CLDP supports. The Monitoring Team suggests that the APC and/or transition specialist cross-reference all assessments with the final list of supports to make sure that all are included or addressed.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: The facility has consistently scored well on post move monitoring activities. Therefore, moving forward, indicators 3, 4, 6, 7, and 8 will be placed in the category of indicators for which less oversight is necessary. However, indicator 5 requires the facility's focused attention. Even though most supports were provided, some very important supports were not provided to one individual. This will remain in active monitoring. The Monitoring Team did not observe post move monitoring because none was scheduled. The Monitoring Team plans to observe post move monitoring and to score indicators 9 and 10 at the next review.			Individuals:								
#	Indicator	Overall Score	153	57							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	100% 2/2	1/1	1/1							
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.	100% 2/2	1/1	1/1							
5	Based on information the Post Move Monitor collected, the individual is (a) receiving the supports as listed and/or as described in the CLDP, or (b) is not receiving the support because the support has been met, or (c) is not receiving the support because sufficient justification is provided as to why it is no longer necessary.	50% 1/2	0/1	1/1							
6	The PMM's scoring is correct based on the evidence.	100% 2/2	1/1	1/1							
7	If the individual is not receiving the supports listed/described in the CLDP, the IDT/Facility implemented corrective actions in a timely manner.	100% 2/2	1/1	1/1							
8	Every problem was followed through to resolution.	100% 2/2	1/1	1/1							
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	Not rated	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not rated	N/A	N/A							

Comments:
3. Post-move monitoring was completed for one visit for Individual #153 and three visits for Individual #57. All four of these post-move monitoring visits were within the required timeframes, included all locations where the individual lived or worked, were done in the proper format, and included comments regarding the provision of every support. The comments were very helpful for the reader to understand how supports were provided and how they were assessed by the PMM.

4. Every support was monitored for every individual for every review. Good detail was provided as to what the PMM observed, what documentation was reviewed, whom she interviewed, and any interactions she had with the individual. Some supports required a provider-completed checklist to be part of the data used to determine provision of the support. The PMM developed a checklist for providers to use to document the provision of many of the supports. The PMM was very aware of the importance of trying to use all three types of evidence when doing post move monitoring (i.e., documentation, interview, and observation). A handful of supports did not meet criterion because data were not available from the provider. They were Individual #153's skill programs, one of his quality of life supports, and monitoring of hypothyroidism.

5. Overall, individuals were receiving most of the supports identified in the CLDP (not all supports were required to be provided during every review period). For his one review, Individual #153 should have received 22 supports. He received 17 of these (i.e., 77%). The ones that were not being provided (or there was no evidence provided to the PMM) for Individual #153 were regarding one of the quality of life supports, toothbrushing, implementation of his behavior support plan, and counseling. Because of the importance of these supports, criterion was not met for Individual #153 for this indicator.

Individual #57 received almost all of the supports that should have been provided. The ones that were not provided (or for which there was no evidence provided to the PMM) were for problems with finding a community neurologist and psychiatrist. Fortunately, these were managed by his PCP and there were no reported problems in either area for Individual #57 during this review period. Further, Individual #57 did not have any history of serious psychiatric issues or seizures for many years. Therefore, although these two supports can be critical for most individuals, for Individual #57, the Monitoring Team (as well as the PMM and IDT) felt that the way these were being covered was acceptable for the interim while the provider continued to work towards obtaining these specialty services, one of which (psychiatry) was established right after the 90-day monitoring.

The PMM made a note about the status of each of the pre move supports during each of her post move monitorings. In all cases, there were no new provider staff, so no new inservicing was required. The few pre move supports that were not about inservicing should have had a comment from the PMM.

6. The PMM correctly scored whether each support was being provided as required. In addition, she provided rationales (when needed) as to how she arrived at her determination of her scoring. The handful of supports that were no rated as meeting criterion were the PMM's scoring of "yes" when "n/a" would have been more appropriate, such as when a support was not yet being implemented because it wasn't required to be implemented yet, or when a support had been completed at a previous post move monitoring.

7-8. The PMM did a thorough job of following up on any and every support that was not being provided, all the way to resolution. Due

to the work of the PMM, individuals received supports that might have otherwise not been provided as they were supposed to have been. This could have ultimately resulted in serious problems for the individuals' health, safety, happiness, and life in the community.

- Individual #153: For toothbrushing, the PMM went back to the home to ensure that they were collecting data, and she went to the day program to remind/prompt them to provide this support. For implementation of the PBSP, she arranged for the El Paso SSLC behavioral health specialist to conduct another training with the provider staff and to do a counseling session with Individual #153, and she spoke with the provider nurse about Individual #153's medications. For counseling, she again spoke with the provider, Individual #153, and the El Paso SSLC IDT. There was little time to do further follow-up on these three as well as the other two supports because Individual #153 returned to the facility shortly after the 7-day post move monitoring.
- Individual #57: For finding a community neurologist and psychiatrist, the PMM kept the IDT informed and maintained ongoing communication with the provider. A psychiatrist was identified shortly after the 90-day post move monitoring review. Four neurologists had been pursued, but one had not yet been identified.

9-10. Post move monitoring did not occur during the week of the onsite review. Therefore, these two indicators could not be scored.

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

Summary: Criteria were met for one of the two individuals. IDTs need to look to the APC and his staff for their expertise and knowledge of the community provider system. A recommendation from the APC and his staff for certain supports to be in place should be taken seriously by the IDT. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 153	57							
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1							

Comments:
10. Individual #57 did not experience any negative events. Individual #153 had numerous problem incidents that resulted in his return to living at the SSLC. These might have been avoided if a more thorough transition had occurred. For instance, Individual #153 was reported to have been doing great at the facility for the months leading up to his transition. He was involved in the transition, participated in meetings, and contributed to the decision to transition back to the home of a family foster care provider with whom he had lived in the past. His mother and his IDT were in support of this. Perhaps due to his stability at El Paso SSLC and his ability to actively participate in his transition and transition-related decisions, the IDT overlooked exhibitions of behavior problems that occurred in the months prior to transition, his refusal to participate in in counseling, and a decision to not pursue employment and instead attend a day habilitation program for socializing.

The APC and his staff reportedly raised questions, concerns, and issues related to some of these decisions. Although, ultimately, it is the IDT's decision regarding transition, in the opinion of the Monitoring Team, IDTs should strongly heed the advice from the APC regarding supports and transition-related concerns, especially regarding those supports that were being provided at the facility, that likely contributed to the success of the individual at the facility, but for which the IDT does not feel are necessary when in the community (e.g., employment, a specialized reinforcement program). The APC at El Paso SSLC had probably the most expertise and knowledge of the community, the provider network, and previous experience with individuals' successes and occasional failures during and after their transitions than anyone else at the facility.

The APC reported that they learned from Individual #153's transition and were making improvements to their transition planning, especially for individuals with histories of challenging behavioral health and psychiatric disorders. For instance, they paired with the local community START program (part of the local intellectual and developmental disability authority). Usually the START program got involved after an individual transitioned or when a need arose. Instead, staff from the START program will become involved while the individual is in transition and still living at El Paso SSLC.

Outcome 4 – The CLDP identified a comprehensive set of specific steps that facility staff would take to ensure a successful and safe transition to meet the individual's individualized needs and preferences.

Summary: This outcome focuses upon a variety of transition activities. El Paso SSLC completed transition assessments for every discipline. They contained recommendations, but more focus needs to be put on how these recommendations may be applied in the individual's new home, work, and community settings. IDTs were very involved in individual's transitions. Some specific activities and considerations for each individual need to occur and be documented. All indicators in this outcome will continue to be actively monitored.

Individuals:

#	Indicator	Overall Score	153	57							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							

14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1								
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1								
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	0% 0/2	0/1	0/1								
18	The APC and transition department staff collaborates with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition.	0% 0/2	0/1	0/1								
19	Pre-move supports were in place in the community settings on the day of the move.	100% 2/2	1/1	1/1								

Comments:

12. El Paso SSLC utilized 14 to 15 different transition assessments. The facility did not review or update the IRRF, but should, or should indicate that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. APCs should ensure that the IDT reviewed the status of the IRRF as part of the transition assessment process.

- All assessments for both individuals were completed within 45 days of their transition.
- Some assessments provided a reasonable history of their stay at the facility. These were nursing, OT, PT, communication, behavioral health (for Individual #153), psychiatry, residential, and recreational.
- Most assessments included recommendations. The nursing assessments for both individuals did not contain recommendations.
- Only the recreational assessments provided recommendations that could be used in the community settings. Many of the assessments appeared to be the ISP annual assessment, that is, without any focus upon the new environments into which the individual would be living and working. This is an area of focus for the facility.
- Overall, one of Individual #153's and one of Individual #57's assessments met all four criteria that are part of this indicator (recreational).

13. There was active participation by IDTs, LARs, and individuals in the transitions of both individuals. For Individual #153, the IDT participated in several discussions about employment and occurrences of behavioral problems during the transition period. The transition was driven primarily by Individual #153 and his LAR (mother). For Individual #57, the IDT was highly involved in all aspects of his transition, such as visiting providers, assessing Individual #57's reaction to providers, managing medical issues that arose during the transition period, and working with provider staff. Responsible SSLC and provider staff were identified, and individuals and LARs participated in decision-making.

14. El Paso SSLC provided multiple trainings to provider staff. The supports included a good listing of which particular staff were to be trained and the content of the training. However, the support should indicate in more detail the type of training (e.g., didactic, role play, in vivo), the specific type of competency to be evaluated (e.g., paper exam, verbal description, role-play demonstration, in vivo demonstration), and criteria for satisfying the training-related supports.

15-17. These three indicators only apply as needed. The El Paso SSLC CLDPs (or any other documentation) did not, but need to, indicate that the IDT considered these transition activities, even if there was a determination that the activity was not needed for the individual.

18. The CLDP only referred to the completion of the local authority's own pre move site review. However, while onsite, the APC described the frequent and varied contact and involvement of the local authority. This should be more detailed in future CLDPs and/or in the transition log.

19. The PMM conducted the pre move site review. These were done thoroughly. The facility also used a detailed day of move checklist that listed all of the items that were to go with the individual on his or her move date and a place for the provider to sign that he or she received each of the items.

Outcome 5 – Individuals have timely transition planning and implementation.												
Summary: Both individuals were scored as meeting criterion, which was good to see, however, given that one individual's speedy transition was unsuccessful and the other individual's transition took 15 months, this indicator will continue to need attention and active monitoring.			Individuals:									
#	Indicator	Overall Score	153	57								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or adequate justification is provided.	100% 2/2	1/1	1/1								

Comments:
20. Individual #153 moved about 90 days after referral. Interestingly, this was a transition that probably should have occurred slower, with more time taken to ensure every support was in place, even though Individual #153 and his team were anxious for him to move as soon as possible.

Individual #57 moved 15 months after referral. The transition logs (written by the transition specialist) detailed the story of his transition. For instance, after referral he was diagnosed with an infectious disease that took one to two months to clear. Then the facility initiated a search for a provider who could meet his needs around his g-tube. A provider was identified, but the IDT did not like the way the day habilitation staff interacted with Individual #57 during a visit and decided to pursue other providers. These did not work out due to house accessibility issues, and lack of available openings. Then Individual #57 had some dental and g-tube issues that took some time to resolve. After a time, a new provider came to town and was explored by the APC and the IDT. A visit was set up, this

provider was chosen, and the various typical transition activities occurred, such as overnight visits and staff training. Thus, El Paso SSLC demonstrated lots of attention to this transition, even though it took longer than 180 days. The facility regularly held meetings to review the status of any referral that was more than 180 days old.

Individual #57's transition may be instructive and informative to anyone interested in understanding the challenges that can occur with transition. This case included examples of the types of variables that impact the individual, IDT, SSLC, and community providers. Community providers put in a lot of time in these transitions, including bearing the expense of maintaining vacancies.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

- Individuals for whom pre-treatment sedation (oral or TIVA/general anesthesia) is approved/included as a need in the ISP, including an indication of whether or not it has been used in the last year, including for medical or dental services;
    - In the past six months, individuals that have refused dental services (i.e., refused to attend a dental appointment or refused to allow completion of all or part of the dental exam or work once at the clinic);
    - Individuals for whom desensitization or other strategies have been developed and implemented to reduce the need for dental pre-treatment sedation;
    - In the past six months, individuals with dental emergencies;
    - Individuals with Do Not Resuscitate Orders, including qualifying condition; and
    - In the past six months, individuals with adverse drug reactions, including date of discovery.
- Lists of:
    - Crisis intervention restraints.
    - Medical restraints.
    - Protective devices.
    - Any injuries to individuals that occurred during restraint.
    - DFPS cases.
    - All serious injuries.
    - All injuries from individual-to-individual aggression.
    - All serious incidents other than ANE and serious injuries.
    - Non-serious Injury Investigations (NSIs).
    - Lists of individuals who:
        - Have a PBSP
        - Have a crisis intervention plan
        - Have had more than three restraints in a rolling 30 days
        - Have a medical or dental desensitization plan in place, or have other strategies being implemented to increase compliance and participation with medical or dental procedures.
        - Were reviewed by external peer review
        - Were reviewed by internal peer review
        - Were under age 22
    - Individuals who receive psychiatry services and their medications, diagnoses, etc.

- A map of the Facility
- An organizational chart for the Facility, including names of staff and titles for medical, nursing, and habilitation therapy departments
- Episode Tracker
- For last year, in alphabetical order by individual, SSLC database printout for Emergency Department Visits (i.e., list of ED visits, name of individual, date, and reason for visit)
- For last year, in alphabetical order by individual, SSLC database printout for Hospitalizations (i.e., list of hospitalizations, name of individual, date, reason for hospitalization, and length of stay)
- Facility policies related to:
    a. PNMT
    b. OT/PT and Speech

c. Medical
d. Nursing
e. Pharmacy
f. Dental

- List of Medication times by home
- All DUE reports completed over the last six months (include background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results)
- For all deaths occurring since the last review, the recommendations from the administrative death review, and evidence of closure for each recommendation (please match the evidence with each recommendation)
- Last two quarterly trend reports regarding allegations, incidents, and injuries.
- QAQI Council (or any committee that serves the equivalent function) minutes (and relevant attachments if any, such as the QA report) for the last two meetings in which data associated with restraint use and incident management were presented and reviewed.
- The facility's own analysis of the set of restraint-related graphs prepared by state office for the Monitoring Team.
- The DADS report that lists staff (in alphabetical order please) and dates of completion of criminal background checks.
- A list of the injury audits conducted in the last 12 months.
- Polypharmacy committee meeting minutes for last six months.
- Facility's lab matrix
- Names of all behavioral health services staff, title/position, and status of BCBA certification.
- Facility's most recent obstacles report.
- A list of any individuals for whom you've eliminated the use of restraint over the past nine months.
- A copy of the Facility's guidelines for assessing engagement (include any forms used); and also include engagement scores for the past six months.
- Calendar-schedule of meetings that will occur during the week onsite.

The individual-specific documents listed below:

- ISP document, including ISP Action Plan pages
- IRRF, including revisions since the ISP meeting
- IHCP
- PNMP, including dining plans, positioning plans, etc. with all supporting photographs used for staff implementation of the PNMP
- Most recent Annual Medical Assessment, including problem list(s)
- Active Problem List
- ISPAs for the last six months
- QIDP monthly reviews/reports, and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request
- QDRRs: last two, including the Medication Profile
- Any ISPAs related to lack of progress on ISP Action Plans, including IHCP action plans
- PNMT assessment, if any
- Nutrition Assessment(s) and consults within the last 12 months

- IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, Restraint Checklists Pre- and Post-Sedation, etc.
- ED transfer sheets, if any
- Any ED reports (i.e., not just the patient instruction sheet)
- Any hospitalization reports
- Immunization Record from the active record
- AVATAR Immunization Record
- Consents for immunizations
- Medication Variance forms and follow-up documentation for the last six months (i.e., include the form and Avatar Report)
- Annual Nursing Assessment, and associated documents (e.g., Braden Scale, weight record)
- Last two quarterly nursing assessments, and associated documents (e.g., Braden Scale, weight record)
- Acute care plans for the last six months
- Direct Support Professional Instruction Sheets, and documentation validating direct support professionals training on care plans, including IHCPs, and acute care plans
- Last three months Eternal Nutrition Flow Record, if applicable
- Last three months Aspiration Trigger Sheets, if applicable
- Last three months Bowel Tracking Sheets (if medium or high risk for constipation and bowel obstruction requiring a plan of care)
- Last three months Treatment Records, including current month
- Last three months Weight records (including current month), if unplanned weight gain or loss has occurred requiring a plan of care
- Last three months of Seizure Records (including current month) and corresponding documentation in the IPN note, if applicable
- To show implementation of the individual's IHCP, any flow sheets or other associated documentation not already provided in previous requests
- Last six months of Physician Orders (including most recent quarter of medication orders)
- Current MAR and last three months of MARs (i.e., including front and back of MARs)
- Last three months Self Administration of Medication (SAMs) Program Data Sheets, as implemented by Nursing
- Adverse Drug Reaction Forms and follow-up documentation
- For individuals that have been restrained (i.e., chemical or physical), the Crisis Intervention Restraint Checklist, Crisis Intervention Face-to-Face Assessment and Debriefing, Administration of Chemical Restraint Consult and Review Form, Physician notification, and order for restraint
- Signature page (including date) of previous Annual Medical Assessment (i.e., Annual Medical Assessment is requested in #5, please provide the previous one's signature page here)
- Last three quarterly medical reviews
- Preventative care flow sheet
- Annual dental examination and summary, including periodontal chart, and signature (including date) page of previous dental examination
- For last six months, dental progress notes and IPNs related to dental care
- Dental clinic notes for the last two clinic visits
- For individuals who received medical and/or dental pre-treatment sedation, all documentation of monitoring, including vital sign sheets, and nursing assessments, if not included in the IPNs.
- For individuals who received general anesthesia/TIVA, all vital sign flow sheets, monitoring strips, and post-anesthesia assessments

- For individuals who received TIVA or medical <u>and/or</u> dental pre-treatment sedation, copy of informed consent, and documentation of committee or group discussion related to use of medication/anesthesia
- ISPAs, plans, and/or strategies to address individuals with poor oral hygiene and continued need for sedation/TIVA
- For any individual with a dental emergency in the last six months, documentation showing the reason for the emergency visit, and the time and date of the onset of symptoms
- Documentation of the Pharmacy's review of the five most recent new medication the orders for the individual
- WORx Patient Interventions for the last six months, including documentation of communication with providers
- When there is a recommendation in patient intervention or a QDRR requiring a change to an order, the order showing the change was made
- Adverse Drug Reaction Forms and follow-up documentation
- PCP post-hospital IPNs, if any
- Post-hospital ISPAs, if any
- Medication Patient Profile form from Pharmacy
- Current 90/180-day orders, and any subsequent medication orders
- Any additional physician orders for last six months
- Consultation reports for the last six months
- For consultation reports for which PCPs indicate agreement, orders or other documentation to show follow-through
- Any ISPAs related to consultation reports in the last six months
- Lab reports for the last one-year period
- Most recent colonoscopy report, if applicable
- Most recent mammogram report, if applicable
- For eligible women, the Pap smear report
- DEXA scan reports, if applicable
- EGD, GES, and/or pH study reports, if applicable
- Most recent ophthalmology/optometry report
- The most recent EKG
- Most recent audiology report
- Clinical justification for Do Not Resuscitate Order, if applicable
- For individuals requiring suction tooth brushing, last two months of data showing implementation
- PNMT referral form, if applicable
- PNMT minutes related to individual identified for the last 12 months, if applicable
- PNMT Nurse Post-hospitalization assessment, if applicable
- Dysphagia assessment and consults (past 12 months)
- IPNs related to PNMT for the last 12 months
- ISPAs related to PNMT assessment and/or interventions, if applicable
- Communication screening, if applicable
- Most recent Communication assessment, and all updates since that assessment
- Speech consultations, if applicable
- Any other speech/communication assessment if not mentioned above, if any within the last 12 months

- ISPAs related to communication
- Skill Acquisition Programs related to communication, including teaching strategies
- Direct communication therapy plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to communication
- Communication dictionary
- IPNs related to speech therapy/communication goals and objectives
- Discharge documentation for speech/communication therapy, if applicable
- OT/PT Screening
- Most recent OT/PT Assessment, and all updates since that assessment
- OT/PT consults, if any
- Head of Bed Assessment, if any within the last 12 months
- Wheelchair Assessment, if any within the last 12 months
- Any other OT/PT assessment if not mentioned above, if any within the last 12 months
- ISPAs related to OT/PT
- Any PNMPs implemented during the last six months
- Skill Acquisition Programs related to OT/PT, including teaching strategies
- Direct PT/OT Treatment Plan, if applicable
- For the last month, data sheets related to SAPs or other plans related to OT/PT
- IPNs related to OT/PT goals and objectives
- Discharge documentation for OT/PT therapy, if applicable
- REISS screen, if individual is not receiving psychiatric services

The individual-specific documents listed below:
- ISP document
- IRRF, including any revisions since the ISP meeting
- IHCP
- PNMP
- Most recent Annual Medical Assessment
- Active Problem List
- All ISPAs for past six months
- QIDP monthly reviews/reports (and/or any other ISP/IHCP monthly or periodic reviews from responsible disciplines not requested elsewhere in this document request)
- QDRRs: last two
- List of all staff who regularly work with the individual and their normal shift assignment
- ISP Preparation document
- These annual ISP assessments: nursing, habilitation, dental, rights
- Assessment for decision-making capacity
- Vocational Assessment or Day Habilitation Assessment

- Functional Skills Assessment and FSA Summary
- PSI
- QIDP data regarding submission of assessments prior to annual ISP meeting
- Behavioral Health Assessment
- Functional Behavior Assessment
- PBSP
- PBSP consent tracking (i.e., dates that required consents (e.g., HRC, LAR, BTC) were obtained
- Crisis Intervention Plan
- Protective mechanical restraint plan
- Medical restraint plan
- All skill acquisition plans (SAP) (include desensitization plans
- SAP data for the past three months (and SAP monthly reviews if different)
- All Service Objectives implementation plans
- Comprehensive psychiatric evaluation (CPE)
- Annual CPE update (or whatever document is used at the facility)
- All psychiatry clinic notes for the past 12 months (this includes quarterlies as well any emergency, urgent, interim, and/or follow-up clinic notes)
- Reiss scale
- MOSES and DISCUS forms for past six months
- Documentation of consent for each psychiatric medication
- Psychiatric Support Plan (PSP)
- Neurology consultation documentation for past 12 months
- For any applications of PEMA (psychiatric emergency medication administration), any IPN entries and any other related documentation.
- Listing of all medications and dosages.
- If any pretreatment sedation, date of administration, IPN notes, and any other relevant documentation.
- If admitted after 1/1/14, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected DFPS investigations for which the individual was an alleged victim,
- Documentation for the selected facility investigations where an incident involving the individual was the subject of the investigation.

- A list of all injuries for the individual in last six months.
- Any trend data regarding incidents and injuries for this individual over the past year.
- If the individual was the subject of an injury audit in the past year, audit documentation.

For specific individuals who have moved to the community:

- ISP document (including ISP action plan pages)
- IRRF
- IHCP
- PSI
- ISPAs
- CLDP
- Discharge assessments
- Day of move checklist
- Post move monitoring reports
- PDCT reports
- Any other documentation about the individual’s transition and/or post move incidents.

APPENDIX B - List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ADR	Adverse Drug Reaction
ADL	Adaptive living skills
AED	Antiepileptic Drug
AMA	Annual medical assessment
APC	Admissions and Placement Coordinator
APRN	Advanced Practice Registered Nurse
ASD	Autism Spectrum Disorder
BHS	Behavioral Health Services
CBC	Complete Blood Count
CDC	Centers for Disease Control
CDiff	Clostridium difficile
CLDP	Community Living Discharge Plan
CNE	Chief Nurse Executive
CPE	Comprehensive Psychiatric Evaluation
CPR	Cardiopulmonary Resuscitation
CXR	Chest x-ray
DADS	Texas Department of Aging and Disability Services
DNR	Do Not Resuscitate
DOJ	Department of Justice
DSHS	Department of State Health Services
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
EC	Environmental Control
ED	Emergency Department
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
ENT	Ear, Nose, Throat
FSA	Functional Skills Assessment
GERD	Gastroesophageal reflux disease
GI	Gastroenterology
G-tube	Gastrostomy Tube
Hb	Hemoglobin

HCS	Home and Community-based Services
HDL	High-density Lipoprotein
HRC	Human Rights Committee
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDT	Interdisciplinary Team
IHCP	Integrated Health Care Plan
IM	Intramuscular
IMC	Incident Management Coordinator
IOA	Inter-observer agreement
IPNs	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IV	Intravenous
LVN	Licensed Vocational Nurse
LTBI	Latent tuberculosis infection
MAR	Medication Administration Record
mg	milligrams
ml	milliliters
NMES	Neuromuscular Electrical Stimulation
NOO	Nursing Operations Officer
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PBSP	Positive Behavior Support Plan
PCP	Primary Care Practitioner
PDCT	Potentially Disrupted Community Transition
PEG-tube	Percutaneous endoscopic gastrostomy tube
PEMA	Psychiatric Emergency Medication Administration
PMM	Post Move Monitor
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan
PTS	Pretreatment sedation

QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
RDH	Registered Dental Hygienist
RN	Registered Nurse
SAP	Skill Acquisition Program
SO	Service/Support Objective
SOTP	Sex Offender Treatment Program
SSLC	State Supported Living Center
TIVA	Total Intravenous Anesthesia
TSH	Thyroid Stimulating Hormone
UTI	Urinary Tract Infection
VZV	Varicella-zoster virus