United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: April 3-7, 2017

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Table of Contents

Background

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

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

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

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

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

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

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

Methodology

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

a. **Selection of individuals –** During the weeks prior to the onsite review, the Monitoring Teams requested various types of information about the individuals who lived at the facility and those who had transitioned to the community. From this information, the Monitoring Teams then chose the individuals to be included in the monitoring review. The Monitors also chose some individuals to be monitored by both Teams. This non-random selection process is necessary for the Monitoring Teams to address a facility's compliance with all provisions of the Settlement Agreement.
b. **Onsite review** – The Monitoring Teams were onsite at the SSLC for a week. This allowed the Monitoring Team to meet with individuals and staff, conduct observations, and review documents. Members from both Monitoring Teams were present onsite at the same time for each review, along with one of the two Independent Monitors.
c. **Review of documents –** Prior to the onsite review, the Monitoring Team requested a number of documents regarding the individuals selected for review, as well as some facility-wide documents. While onsite, additional documents were reviewed.
d. **Observations** – While onsite, the Monitoring Team conducted a number of observations of individuals and staff. Examples included individuals in their homes and day/vocational settings, mealtimes, medication passes, Positive Behavior Support Plan (PBSP) and skill acquisition plan implementation, Interdisciplinary Team (IDT) meetings, psychiatry clinics, and so forth.
e. **Interviews** – The Monitoring Teams interviewed a number of staff, individuals, clinicians, and managers.
f. **Monitoring Report** – The monitoring report details each of the various outcomes and indicators that comprise each Domain. A percentage score is made for each indicator, based upon the number of cases that were rated as meeting criterion out of the total number of cases reviewed. In addition, the scores for each individual are provided in tabular format. A summary paragraph is also provided for each outcome. In this paragraph, the Monitor provides some details about the indicators that comprise the outcome, including a determination of whether any indicators will be moved to the category of requiring less oversight. Indicators that are moved to this category will not be monitored at the next review, but may be monitored at future reviews if the Monitor has concerns about the facility's maintenance of performance at criterion. The Monitor makes the determination to move an indicator to the category of requiring less oversight based upon the scores for that indicator during this and previous reviews, and the Monitor's knowledge of the facility's plans for continued quality assurance and improvement. In this report, any indicators that were moved to the category of less oversight during previous reviews are shown as shaded and no scores are provided. The Monitor may, however, include comments regarding these indicators.

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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, were moved to the category of requiring less oversight after the last review. During this review 12 other indicators had sustained high performance scores and will be moved to the category of requiring less oversight. These were in the areas of restraint, incident management, and quality assurance (regarding DUEs) and included two full outcomes: incident management outcome 9, and quality assurance outcome 4. One indicator, in incident management outcome 8, however, was moved back into the category of active monitoring.

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

The overall usage of crisis intervention restraint at El Paso SSLC decreased markedly compared with the past two reviews. This was good to see. When census-adjusted compared with the other facilities, El Paso SSLC was now in the middle (i.e., five facilities had a higher rate, seven were lower). Improvements were also seen in the frequency of restraint-related injuries. Much focus had been placed on Individual #13, who had a very high rate of crisis intervention restraint in the past. The frequency of crisis intervention restraint for him was greatly reduced, however, the frequency and durations of his aggressive, destructive, and tantrum behavior remained very high.

Progress in restraint management was also evidenced by seven indicators moving to the category of requiring less oversight. Staff were knowledgeable about individuals' specific restraint requirements. Some focus on follow-up to restraint was needed, such as completion of recommendations from restraint reviews and psychiatry follow-up.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: timely monitoring of individuals who are restrained; documenting vital signs and reattempting vital signs when individuals initially refuse; monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained.

Abuse, Neglect, and Incident Management

El Paso SSLC regularly reviewed trends. This was a long-standing practice at the facility; eight of the 10 investigations met all criteria for this important outcome (1). Most allegations and injuries were reported appropriately. El Paso SSLC routinely utilized video surveillance recordings to contribute to investigations and sometimes in determination of whether an incident should be reported for investigation. Investigations included appropriate recommendations and all recommendations were implemented in a timely manner.

Non-serious injury investigations were not being conducted for all individuals as they should be. This needs some attention for this indicator (14) to maintain placement in the category of requiring less oversight. El Paso SSLC collected, graphed, and presented lots of different data regarding abuse, neglect, injuries, investigations, etc. There was, however, little analysis done of these data.

Other

The IDT for the individual reviewed by the Monitoring Team who had pretreatment sedation reviewed this need at the ISP and developed a plan to reduce future usage, however, the plan was never implemented.

It was good to see that the Center completed clinically significant DUEs, and conducted necessary follow-up. Given the Center's performance during this review and the last two reviews, this outcome will move to the category requiring less oversight.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.	
Summary: The overall usage of crisis intervention restraint at El Paso SSLC decreased markedly compared with the past two reviews. This was good to see. When census-adjusted compared with the other facilities, El Paso SSLC was now in the middle (i.e., five facilities had a higher rate, seven were lower). Improvements were also seen in the frequency of restraint-related injuries. Much focus had been placed on Individual #13, who had a very high rate of crisis intervention restraint in the past. The frequency of crisis intervention restraint for him was greatly reduced, however, the frequency and durations of his aggressive, destructive, and tantrum	Individuals:

behavior remained very high. Indicator 1 showed good improvement since the last review and indicator 2 remained at about the same. Both of these indicators will remain in active monitoring.											
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	83% 10/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	73% 8/11	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (June 2016 through February 2017) were reviewed.

Overall, the usage of crisis intervention restraint at El Paso SSLC had reduced markedly compared with the last two reviews (and especially when compared with the last review). This was likely due to focus across the facility, by facility management, and by the behavioral health services department. It included a strong focus upon Individual #13, who accounted for the vast majority (but not all) of the crisis intervention restraints at the time of the last review. The frequency of restraints for Individual #13 was greatly reduced (which was good to see), however, his aggressive, destructive, and tantrum behaviors continued at a high rate, always causing great disruption (and potential injury) to staff and individuals. El Paso SSLC would benefit from behavioral health consultation on this individual. A data set, assembled by the behavioral health services department during the onsite review week, may be helpful. It included the frequency (7-19 occurrences per month) and duration of each episode (around 30 minutes), and whether crisis intervention restraint was implemented during the episode (usually not implemented).

The usage of physical crisis intervention restraint paralleled the overall usage of crisis intervention restraint because all (but two) crisis intervention restraints were crisis intervention physical restraints. There were only two occurrences of crisis intervention chemical restraints and no occurrences of crisis intervention mechanical restraints during the nine-month review period. The average duration of a physical restraint remained under three minutes, the second lowest among all the facilities. There were no individuals who had protective mechanical restraint for self-injurious behavior. The number of restraint-related injuries had also greatly decreased (all were deemed non-serious), another indication of the facility-wide attention being paid to restraint management. The number of individuals who received crisis intervention remained about the same as at the last review, approximately five to six each month.

There were zero occurrences of non-chemical restraints for medical or dental procedures, and a decreasing trend in the use of chemical restraints for medical procedures. The use of chemical restraint for dental procedures was limited to TIVA and was approximately 20 individuals per quarter (specific data were not available).

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

The restraint reduction committee was re-initiated since the last review. It met monthly and the minutes were reviewed by the Monitoring Team. It was good to see the committee active. Minutes showed that specific individuals were discussed in detail. It is important for this committee to review specific individuals. In addition, the committee should review facility-wide data (such as the set of data discussed in this indicator) and determine if actions should be taken.

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. Of these, all four received crisis intervention physical restraints (Individual #156, Individual #153, Individual #13, Individual #26) and one received crisis intervention chemical restraint (Individual #153). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for one of the four (Individual #156). The other individuals reviewed by the behavioral health monitoring team had no occurrences of crisis intervention restraint and were scored positively for this indicator.

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 management of restraint usage had greatly improved at El Paso. For those aspects that met criteria at 100% for this review as well as the past two reviews, those indicators will be moved to the category of requiring less oversight (3, 4, 5, 6, 7, 8, 10). Indicators 9 (regarding ensuring all supports are in place) and 11 (regarding identifying contra-indications for restraint usage) will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	156	153	13	26					
3	There was no evidence of prone restraint used.	100% 6/6	2/2	2/2	1/1	1/1					
4	The restraint was a method approved in facility policy.	100% 6/6	2/2	2/2	1/1	1/1					
5	The individual posed an immediate and serious risk of harm to him/herself or others.	100% 6/6	2/2	2/2	1/1	1/1					
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.	100% 5/5	2/2	1/1	1/1	1/1					
7	There was no injury to the individual as a result of implementation of the restraint.	100% 6/6	2/2	2/2	1/1	1/1					
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.	100% 6/6	2/2	2/2	1/1	1/1					
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/4	Not rated	0/2	0/1	0/1					

10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	100% 6/6	2/2	2/2	1/1	1/1					
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	0% 0/6	0/2	0/2	0/1	0/1					

Comments:
The Monitoring Team chose to review six restraint incidents that occurred for four different individuals (Individual #156, Individual #153, Individual #13, Individual #26). Of these, five 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.

9. Because criterion for indicator #2 was met for one of the four individuals, this indicator was not scored for her. For Individual #153, Individual #13, and Individual #26, there was no evidence of implementation of PBSPs, QIDP monthly reviews, and for Individual #153, no implementation of earlier recommendation for him to receive counseling supports (though this had since been put in place).

11. Information about contra-indications for implementation of crisis intervention restraint was not included in any of the IRRF sections of the ISP for any individual, whether it was in the old form IRRF or in the new electronic record IRRF format.

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

Summary: This indicator will remain in active monitoring. Refresher training for all staff regarding prohibited restraints may be needed.

Individuals:

#	Indicator	Overall Score	156	153	13	26					
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	67% 2/3	1/1	Not rated	0/1	1/1					

Comments:
12. One staff member was unable to identify restraints that were prohibited by policy and practice. All staff, however, knew the details regarding restraints specific to the individuals who most frequently had crisis intervention restraint. Staff for Individual #153 were unable to be interviewed for this indicator due to supervision duties with individuals.

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.

Summary: Performance improved compared with the last two reviews. With sustained high performance, these indicators might move to the category of requiring less oversight after the next review. They will remain in active

Individuals:

monitoring.											
#	Indicator	Overall Score	156	153	13	26					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 6/6	2/2	2/2	1/1	1/1					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A					
Comments:											

Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.											
Summary: Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: timely monitoring individuals who are restrained; documenting vital signs and reattempting vital signs when individuals initially refuse; monitoring individuals for potential side effects of chemical restraints and providing follow-up for abnormalities; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and ensuring documentation is accurate and consistent in the various places that restraint documentation is maintained. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	156	153	13	26					
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	17% 1/6	0/2	0/2	1/1	0/1					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	17% 1/6	0/2	0/2	1/1	0/1					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	17% 1/6	0/2	0/2	1/1	0/1					
Comments: The crisis intervention restraints reviewed included those for: Individual #156 on 10/7/16 at 3:48 p.m., and 11/10/16 at 5:15 p.m.; Individual #153 on 12/14/16 at 4:25 pm. (chemical), and 2/9/17 at 2:10 p.m.; Individual #13 on 2/10/17 at 3:26 p.m.; and Individual #26 on 1/20/17 at 12:36 p.m. a. It was positive to see that nursing staff timely and properly monitored Individual #13 during and after his restraint on 2/10/17 at 3:26 p.m.											

For Individual #153's restraint on 12/14/16 at 4:25 pm. (chemical), the nurse documented his behaviors and mental status well.

However, overall, for the restraints reviewed, nursing staff's monitoring and documentation were generally poor. Problems were noted with regard to:

- Nursing staff documenting that individuals "refused vital signs," but an individual's cooperation is not necessary to obtain respirations and/or breathing status;
- At times, the Face-to-Face checklist stated "Yes" for the nurse checking vital signs and/or mental status, but corresponding details were not found in IView and/or IPNs;
- Late assessments (e.g., for Individual #153's chemical restraint on 12/14/16 at 4:25 pm., for which the first nursing assessment of vital signs occurred at 5:50 p.m.; for Individual #153 on 2/9/17 at 2:10 p.m., for which the first nursing entry was made seven hours after the restraint; and for Individual #26 on 1/20/17 at 12:36 p.m., for which the nurse was notified at 12:57 p.m., and arrived at 1:37 p.m.); and
- Mental status entries providing no details regarding the individual's behaviors, such as "no change from baseline."

b. and c. Nursing IPNs often were not found for follow-up attempts to obtain vital signs for individuals who refused, or assessments for injuries, or conflicting information was noted in the Face-to-Face checklists and other documentation related to restraints.

For Individual #153's chemical restraint on 12/14/16 at 4:25 pm., the first nursing assessment of vital signs occurred at 5:50 p.m. At that time, the individual's blood pressure was 90/60 (i.e., systolic noted as low), followed by a 6:20 p.m. blood pressure reading of 82/62. However, it did not appear that the nurse notified the physician regarding the change in blood pressure, or that the nurse reviewed what his baseline vital signs were.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.												
Summary: Restraints were documented correctly, an improvement from the last review. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	156	153	13	26						
15	Restraint was documented in compliance with Appendix A.	100% 6/6	2/2	2/2	1/1	1/1						
Comments:												

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.	
Summary: Both indicators will remain in active monitoring. A system for ensuring implementation of recommendations is needed.	Individuals:

#	Indicator	Overall Score	156	153	13	26					
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	83% 5/6	2/2	2/2	0/1	1/1					
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	0% 0/3	0/1	N/A	0/1	0/1					

Comments:
16. For Individual #13, the post restraint ISPA was 10 days after the restraint.

17. For Individual #156 10/7/16, the facility self-reported that recommendations were not completed. For Individual #13, the recommendation regarding assigned staff schedules was reported to have been modified, but there was no evidence of implementation. For Individual #26, there was no evidence of implementation of the three recommendations.

Outcome 15 – Individuals who receive chemical restraint receive that restraint in a safe manner. (Only restraints chosen by the Monitoring Team are monitored with these indicators.)

Summary: The various criteria for these indicators were not met, though it was good to see that multiple medications were not used. Crisis intervention chemical restraint rarely occurred at El Paso SSLC. Even so, these indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	153								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	0% 0/1	0/1								
48	Multiple medications were not used during chemical restraint.	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 one individual. The Administration of Chemical Restraint: Consult and Review was not performed within the 10-day time frame for the example reviewed. There was no documentation of psychiatric follow-up following the restraint episode.

Abuse, Neglect, and Incident Management

Outcome 1- Supports are in place to reduce risk of abuse, neglect, exploitation, and serious injury.											
Summary: El Paso SSLC regularly reviewed trends. This was a long-standing practice at the facility and contributed to good performance on the relevant sub-indicators of indicator 1. Eight of the 10 investigations met all criteria for this important outcome. The two that did not were related to absence of checking the functioning of an alert device, and not including self-injurious behavior in the PBSP. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	60	156	153	159	112	37	15	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	80% 8/10	1/1	0/1	0/1	2/2	1/1	1/1	2/2	1/1	

Comments:

The Monitoring Team reviewed 10 investigations that occurred for eight individuals. Of these 10 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, five unconfirmed, one administrative referral). The other three were for facility investigations of a serious injury (fracture), a sexual incident, and a suicide threat. 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 #161, UIR 17-026, DFPS 44868618, administrative referral of allegation of neglect, 10/7/16
- Individual #60, UIR 17-092, DFPS 45123238, unconfirmed allegation of neglect, 1/25/17
- Individual #156, UIR 17-088, DFPS 45064712, unconfirmed allegation of neglect, 1/6/17
- Individual #153, UIR 17-085, DFPS 45035893, unconfirmed allegation of physical abuse, 12/29/16
- Individual #153, UIR 17-072, suicide threat, 12/13/16
- Individual #159, UIR 17-017, DFPS 44805527, confirmed allegation of neglect, 9/23/16
- Individual #112, UIR 17-080, DFPS 45017845, unconfirmed allegation of neglect, 12/22/16
- Individual #37, UIR 17-066, DFPS 44997711, unconfirmed allegation of emotional abuse, 12/8/16
- Individual #37, UIR 16-214, sexual incident, 8/22/16
- Individual #15, UIR 17-023, discovered fracture, femur, 10/3/16

1. For all 10 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.

For all investigations, criminal background checks and duty to report forms were completed. In fact, for all but two of the investigations, all four of the above sub-indicators were met. For many of the investigations, there was no trend identified by the facility or by the Monitoring Team (i.e., no prior occurrences). The two that did not meet criteria for all four sub-indicators were:

- Individual #60 UIR 17-092 because her fall alert device was not operating properly and there was no evidence to suggest that the device was regularly checked to make sure it was working.
- Individual #156 UIR 17-088 because the incident involved her trying to hurt herself with a butter knife, a behavior she had a history of exhibiting, and one which was not included in her PBSP.

There were no individuals at El Paso SSLC who were deemed to be chronic callers. Thus, there were no streamlined investigations conducted and there were no unfounded dispositions of any investigation during this review period.

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.

#	Indicator	Overall Score	Individuals: 161	60	156	153	159	112	37	15	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	90% 9/10	0/1	1/1	1/1	2/2	1/1	1/1	2/2	1/1	

Comments:

2. The Monitoring Team rated nine of the investigations as being reported correctly. The one other was rated as being reported late or improperly. 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.

- Individual #161, UIR 17-026: Per the UIR (on page 4), the incident occurred at 1:45 am and was reported to facility director/designee at 3:10am (on page 8), more than one hour later. The facility, in the UIR recommendations (on page 16) acknowledged this.

El Paso SSLC routinely utilized video surveillance recordings to contribute to investigations and sometimes in determination of whether an incident should be reported for investigation. This was good to see.

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:

#	Indicator	Overall Score	Individuals:								

3	Staff who regularly work with the individual are knowledgeable about ANE and incident reporting	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.
4	The facility had taken steps to educate the individual and LAR/guardian with respect to abuse/neglect identification and reporting.	
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.	
	Comments:	

Outcome 4 – Individuals are immediately protected after an allegation of abuse or neglect or other serious incident.												
Summary:			Individuals:									
#	Indicator	Overall Score										
6	Following report of the incident the facility took immediate and appropriate action to protect the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments: 6. In six cases, the UIR noted (on page 1) that staff were reassigned, but there was no date/time noted, therefore, it was impossible to validate that the reassignment was immediate. This, however, seemed to be a general problem with the new electronic data system, which appeared to be corrected for the future (i.e., a templated space for data/time of reassignment was added). For this review, the Monitoring Team accepted alternate documentation showing reassignment date and time.												

Outcome 5– Staff cooperate with investigations.												
Summary:			Individuals:									
#	Indicator	Overall Score										
7	Facility staff cooperated with the investigation.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Outcome 6– Investigations were complete and provided a clear basis for the investigator's conclusion.												
Summary:			Individuals:									
#	Indicator	Overall Score										
8	Required specific elements for the conduct of a complete and thorough investigation were present. A standardized format was	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										

	utilized.	
9	Relevant evidence was collected (e.g., physical, demonstrative, documentary, and testimonial), weighed, analyzed, and reconciled.	
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)	

Comments:
9-10. Although these indicators remain in the category of requiring less oversight, the Monitoring Team's review of an additional investigation pointed to the need for the facility to ensure that investigations are conducted completely. While onsite, the Monitoring Team observed possible incorrect application of a crisis intervention physical restraint in a prone position. This was ultimately investigated as DFPS 45232086 and an unconfirmed finding was made. The investigation, however, did not thoroughly analyze and reconcile all of the evidence. For instance, facility staff statements were deemed credible, but no comments were provided about the credibility of statements from the other witnesses, some of whom described the individual being on his stomach (for a brief period); and there were differences between witnesses in their descriptions of the individual rolling over versus falling to the ground.

Outcome 7– Investigations are conducted and reviewed as required.

Summary:		Individuals:								
#	Indicator	Overall Score								
11	Commenced within 24 hours of being reported.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.								
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).									
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.									

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: Some individuals did not have any non-serious injuries that warranted a non-serious injury investigation. For three of the three individuals who did have discovered injuries, non-serious injury investigations were not conducted, but should have been. The Monitoring Team came across these absences during review	Individuals:

of each individual's case. Given this low level of performance (i.e., 0 out of 3), indicator 15 will be moved back into active monitoring.											
#	Indicator	Overall Score									
14	The facility conducted audit activity to ensure that all significant injuries for this individual were reported for investigation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight. However, due to low performance, indicator 15 will be returned to active monitoring.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.										

Comments:

15. Three individuals did not have non-serious injury investigations conducted, but should have for the following:
    - Individual #156: There were three injuries that should have been subjected to a non-serious injury investigation: 12/14/16 eye, 11/26/16 mouth/lip/eye, and 9/21/16 head/scalp.
    - Individual #112: There was one injury that should have been subjected to a non-serious injury investigation: 6/1 eye.
    - Individual #15: There were two injuries that should have been subjected to a non-serious injury investigation: 6/1 scratch to ear and 8/20 scratch to eye.

Given this low level of performance, 63%, this indicator will be put back into the category of active monitoring.

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 last two reviews (with one exception in October 2015). In the last review, the Monitor stated that, with sustained performance, these indicators might move to the category of requiring less oversight after this review. Given the sustained high performance shown below, these three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	161	60	156	153	159	112	37	15	
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	100% 9/9	1/1	1/1	1/1	2/2	1/1	1/1	1/1	1/1	
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.	100% 3/3	1/1	N/A	N/A	N/A	1/1	N/A	N/A	1/1	
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.	100% 7/7	N/A	1/1	1/1	2/2	N/A	1/1	1/1	1/1	

Comments: 17. In the review period, there were four investigations with confirmations of physical abuse 2 confirmations. None of the staff confirmed were retained.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.												
Summary: This outcome consists of facility indicators. El Paso SSLC collected, graphed, and presented lots of different data regarding abuse, neglect, injuries, investigations, etc. There was, however, little analysis done of these data. These 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.	No										
21	When a negative pattern or trend was identified and an action plan was needed, action plans were developed.	No										
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 tracked to completion.	No										
Comments: 19-23. El Paso SSLC collected, graphed, and presented lots of different data regarding abuse, neglect, injuries, investigations, etc. There was, however, little analysis done of these data. These indicators will remain in active monitoring.												

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.												
Summary: N/A			Individuals:									
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10	
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. Based on the documentation provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered TIVA or oral pre-treatment sedation.										

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	N/A									
	Comments: Based on the documentation provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for medical treatment.										

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: For the one individual to whom this outcome applied, it was good to see that the IDT identified the need for PTS and for a plan to possibly reduce its future use. Plans, however, were not developed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179								
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 1/1	1/1								
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 1/1	1/1								
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.	0% 0/1	0/1								
4	Action plans were implemented.	0% 0/1	0/1								

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

Comments:
This outcome and its indicators applied to Individual #179. Individual #179 received pretreatment sedation for a dental procedure on 3/9/16.

1. His most recent ISP and the pretreatment sedation assessment form dated 3/9/16 identified Individual #179's need for PTS.

2. The IDT began a dental brushing plan to reduce the use of PTS in the future. This was good to see.

3-6. The ISP indicated that Individual #179 would come to the dental clinic twice a week, however, this plan was not written in SAP, SO, or IHCP format.

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	72	46	140						
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 3/3	1/1	1/1	1/1						
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/3	0/1	0/1	0/1						
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/3	0/1	0/1	0/1						
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/3	0/1	0/1	0/1						
e.	Recommendations are followed through to closure.	0%	0/1	0/1	0/1						

		0/3									

Comments: a. Since the last review, three individuals died. The Monitoring Team reviewed all three deaths. Causes of death were listed as:

- On 5/31/16, Individual #72 at the age of 63 of hypertensive and atherosclerotic cardiovascular disease and seizure disorder (per the autopsy);
- On 12/30/16, Individual #46 at the age of 70 of respiratory failure, mega colon, and quadriparesis; and
- On 2/6/17, Individual #140 at the age of 34 of epilepsy.

b. through d. A number of issues were identified through the death reviews that did not result in recommendations. Identifying concerns related to medical and other care provided to individuals who have died is an important part of the mortality review process. Equally important, though, is developing and implementing follow-up plans to prevent their recurrence. Some examples of concerns identified included PCPs not conducting follow-up evaluations, delays in PCPs completing assessments, a vagus nerve stimulator (VNS) battery not being replaced, and following proper emergency procedures. In addition, evidence was not submitted to show the Center conducted thorough reviews of nursing care. As a result of these concerns, the Monitoring Team could not draw the conclusion that sufficient recommendations were included in the administrative and clinical death reviews.

Of significant concern, all three deaths raised concerns or documented information/recommendations related to emergency response, including initiation of Emergency Response (e.g., knowing the number to call for an emergency), performing cardio pulmonary resuscitation (CPR) in accordance with standards, and documenting the working status of equipment.

e. The recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "the [emergency] number should be placed on all phones in general areas where the individuals frequent throughout the facility" resulted in signs being placed on phones. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required review of drills and actual emergencies to determine whether or not staff were calling the emergency number as needed, or if another solution needed to be considered.

In addition, the Center did not submit a log that defined implementation dates, who was responsible, and/or completion dates with references to how/who confirmed completion.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	ADRs are reported immediately.	0% 0/1	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A
b.	Clinical follow-up action is completed, as necessary, with the	0%			0/1						

	individual.	0/1									
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	0% 0/1			0/1						
d.	Reportable ADRs are sent to MedWatch.	0% 0/1			0/1						

Comments: a. through d. Center staff had not identified and/or reported/classified adverse drug reactions for any of the individuals reviewed.

However, given that in its review of records, the Monitoring Team identified a potential adverse drug reaction that was unreported, the Center's surveillance and reporting system for adverse drug reactions appeared to require improvement. More specifically:

- In November 2015, a DEXA scan showed osteoporosis, and in October 2016, Individual #15 had an atypical hip fracture. The orthopedist noted in the consult that this atypical fracture could potentially be related to the use of denosumab. Of note, the internal medicine consultant decided to continue its use even though the specialist suggested discontinuing it. There was no referral to endocrinology for additional evaluation of an individual with osteoporosis who sustained an atypical hip fracture while being treated with denosumab. The association of an atypical hip fracture and the use of denosumab is potentially an FDA-reportable event.

In its comments on the draft report, the State indicated: "Paperwork was submitted for individual [sic] #15 concerning brain atrophy and AEDs as well as for individual [sic] #10 concerning hypophosphatemia and insulin. Documentation submitted was for potential adverse drug reactions investigated and discussed at P&T. Neither case was determined to be an ADR." The Adverse Drug Reaction Reporting procedure (revised 2/2017) requires reporting of suspected ADRs, including completion of the ADR form and the Naranjo probability scale. The completed ADR form is then discussed in the Pharmacy and Therapeutics Committee and a decision is made regarding the probability that an ADR occurred. If Center staff thought these were potential ADRs, they should have completed ADR forms, but they did not do so for either one. The physician on the Monitoring Team did not view either of these events as potential ADRs. Given that Center staff did not take the initial step of reporting them as potential ADRs, they are not included in the scoring for this section.

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 two review periods and during this review period, the Center completed clinically significant DUEs and followed up to closure on recommendations, Indicators a and b will move to the category requiring less oversight.		Individuals:
#	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	100%

	the DUE.	3/3

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

- A DUE on Metabolic Syndrome that was presented to the Pharmacy and Therapeutics (P&T) Committee in February 2017;
- A DUE on Hyperprolactinemia that was presented to the P&T Committee in October 2016; and
- A DUE on Naltrexone that was presented to the P&T Committee in September 2016.

The Center completed follow-up on each of the completed DUEs.

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

This Domain contains 31 outcomes and 140 underlying indicators in the areas of individual support plans, and development of plans by the various clinical disciplines. At the last review, 12 of these indicators (in psychiatry, medical, dental, nursing, and communication) were moved the category of requiring less oversight. For this review, three other indicators were moved to this category, in ISPs and skill acquisition plans. No entire outcomes were moved to less oversight. Three indicators in dental outcome 3, however, were moved back into active monitoring.

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

Assessments

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for all the risk ratings reviewed, it was not clear that the risk ratings were accurate. In addition, when individuals experience changes in status, IDTs need to timely review related risk ratings, and make changes, as appropriate.

There are a number of individuals at El Paso SSLC with histories, and current exhibitions, of complex challenging behavior disorders. The facility might benefit from additional behavior analyst consultation in the development and modification of their behavioral treatment programs.

Two of six IDTs considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting. None of the IDTs arranged for and obtained needed, all relevant assessments prior to the ISP meeting.

ISPs did not adequately address barriers to achieving goals and learning new skills.

None of the individuals had an appropriately constituted full IDT who participated in the planning process. The psychiatric provider, however, attended most ISP meetings. It was also good to see that QIDPs were knowledgeable regarding supports and services.

Three of the nine individuals had quality annual medical assessments that included the necessary components and addressed individuals' needs. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

It was concerning that the Center did not provide copies of dental examinations for any of the individuals reviewed. As a result, the indicator related to the timeliness of dental exams will move back to active oversight. In addition, the Center should continue to focus on the quality of dental summaries.

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

It was positive that individuals' IDTs generally referred them to the Physical and Nutritional Management Team (PNMT) within five days of a qualifying event, and the PNMT completed a review within five days of the referral. It also was positive that as needed, a Registered Nurse (RN) Post-Hospitalization Review was generally completed for the individuals reviewed, and the PNMT discussed the results. The Center should focus on sustaining its progress in these areas, as well as completing PNMT comprehensive assessments for individuals needing them, which was a significant problem during this review. In doing so, the Center should conduct quality PNMT comprehensive assessments that fully address the components detailed in the audit tool.

As noted in the last report, El Paso SSLC made improvements with regard to the quality of OT/PT assessments, and this progress continued, which was good to see. To continue down the path of improvement, Center clinicians are encouraged to use the audit tool as a checklist as they complete their assessments, and to focus on the adaptive equipment and recommendation sections of the assessments and updates.

There was progress in ensuring that all individuals who needed a PBSP had a PBSP (i.e., this was the case for all but one individual). Some individuals had PBSP data that were reliable.

Individualized Support Plans

The development of individualized, meaningful personal goals was not yet at criteria, but much progress was evident. All six ISPs, for instance, included three or more goals that met criteria, and two ISPs had goals that met criteria in five of the six areas (i.e., all except health/wellness IHCP goals). Further, all but two of these 23 goals were written in measurable terms.

Seven of the 11 indicators of ISP outcome 3 showed some improvement since the last review and none showed a decrease. Ten goals had action plans that were likely to lead to the accomplishment of the goal. This was very good to see.

Unfortunately, none were implemented timely, sufficiently, correctly, and with adequately collected data to determine progress. IDTs met often in response to incidents and medical issues, but less frequently to review progress or revise supports and services. When recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented.

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.

In psychiatry, it was good to see that the facility had begun to develop goals regarding reductions in psychiatric symptoms. Overall, there need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status. The goals need to be measurable, have a criterion for success, be presented to the IDT… appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review.

All individuals had SAPs, though given the many needs of the individuals, there were very few SAPs created for them. Almost all individuals had two or less SAPs. The new SAP plan (begun in April 2017) looked to address many of the issues with the current SAPs. The group assigned to this task was motivated and the Monitoring Team shares the facility's optimism in seeing improvements at the next monitoring review.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.	
Summary: The development of individualized, meaningful personal goals in six different areas, based on the individual's preferences, strengths, and needs was not yet at criteria, but much progress was evident as described below. All six ISPs, for instance, included three or more goals that met criteria, and two ISPs had goals that met criteria in five of the six areas (i.e., all except health/wellness IHCP goals) for a total of 23 goals that met criteria. This was very good progress since the last review. Further, all but two of these 23 goals were written in measurable terms, also demonstrating good progress. Unfortunately, none were implemented sufficiently, correctly, and with adequately collected data to determine progress. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	156	111	37	153	15	32			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	3/6	4/6	5/6	5/6	3/6	3/6			
2	The personal goals are measurable.	0% 0/6	2/6	4/6	4/6	5/6	3/6	3/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #111, Individual #37, Individual #156, Individual #153, Individual #15, Individual #32). 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.

1. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and also need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology. None of the six individuals had individualized goals in all six areas, however, there was significant improvement in the development of individualized goals based on preferences.

For these six individuals, the IDT had defined some personal goals that met criterion for being individualized based on the individual's preferences and strengths. Overall, 23 of 36 personal goals met criterion for this indicator. This was an improvement from the past review when only nine of 36 goals met criterion. IDTs particularly struggled with writing individualized health care goals. Goals that met criterion included:

- Individual #111's goals for recreation/leisure, relationships, greater independence, and living options.
- Individual #37's goals for leisure/recreation, relationships, employment, greater independence, and living options.
- Individual #156's goals for leisure/recreation, relationships, and work/day.
- Individual #153's goal for leisure/recreation, relationships, employment, greater independence, and living options.
- Individual #15's goals for leisure/recreation, relationships, and greater independence.
- Individual #32's goals for recreation/leisure, relationships, and greater independence and living options.

Although IDTs had created the above goals (ones that were more individualized and based on known preferences), few had been fully implemented. Thus, individuals did not have person-centered ISPs that were really leading them towards achieving their personal goals. The facility needs to focus on barriers that are preventing individuals from achieving their goals and develop plans to address those barriers.

Examples of goals that did not meet criterion because they were not aspirational, individualized, and/or based on preferences included:

- Individual #111's work/day goal to be prompted to engage in activities.
- Individual #156's greater independence goal to increase her skills of daily living.
- Individual #15 did not have a work/day goal and his living option goal to continue to live at El Paso SSLC was not aspirational.
- Individual #32's work goal to attend the workshop was not individualized based on his preferences.

The facility had additional supports in place to help IDTs develop more meaningful ISPs, including support from subject matter experts and the QIDP Coordinator. In addition, IDT members had received additional training on ISP development. There were improvements in the ISP-preparation process that also were also leading towards the development of better goals.

2. When personal goals for the ISPs did not meet the criterion described above in indicator 1, there can be no basis for assessing compliance with measurability or the individual's progress towards its achievement. The presence of a personal goal that meets criterion is a prerequisite to this process. Twenty-one of the 23 personal goals that met criterion for indicator 1 also met criterion for measurability. This was another sign of progress for the QIDPs and IDTs.

The goals that were not measurable were Individual #156's work goal to learn skills that will help her gain employment in the community and earn money and Individual #37's leisure goal to learn to operate a computer. Both were not specific enough to allow staff to determine when the goal was achieved. Specific identifiable behavioral objectives should be stated in the goal.

3. For the 21 goals that were determined to be measurable, only one had reliable and valid data available to determine if the individual met, or was making progress towards achieving, his or her overall personal goals (Individual #111's day goal). As noted throughout this report, it was not possible to determine if ISP supports and services were being consistently implemented or to determine the status of goals due to the lack of data and documentation provided by the facility. It appeared that few goals were consistently implemented.

The facility reported that QIDPs and other team members would soon be participating in additional training offered by the state office on ISP development. The training will be focused on assessments, SAP development, and overall implementation. Hopefully, this will assist the IDTs in developing more functional goals that will support individuals to learn new skills based on their preferences.

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. That being said, seven of the 11 indicators showed some improvement since the last review and none showed a decrease. A focus area for the facility (and its QIDP department) is to ensure the actions plans meet these various 11 items. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	156	111	37	153	15	32			

		Score									
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	1/6	2/6	3/6	1/6	2/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	67% 4/6	0/1	1/1	1/1	1/1	1/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			
12	ISP action plans integrated strategies to minimize risks.	17% 1/6	0/1	0/1	0/1	1/1	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	0/1	0/1	0/1	1/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	0/1	0/1	1/1	1/1	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.	33% 2/6	0/1	0/1	1/1	1/1	0/1	0/1			
16	ISP action plans supported opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals and needs.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
17	ISP action plans were developed to address any identified barriers to achieving goals.	17% 1/6	0/1	0/1	0/1	1/1	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	2/6	0/6	1/6			

Comments:

8. Some personal goals did not meet criterion in the ISPs, as described above in indicator 1, therefore, those action plans could not be evaluated in this context. A personal goal that meets criterion is a prerequisite for such an evaluation. Action plans are evaluated further below in terms of how they may address other requirements of the ISP process.

For the 23 personal goals that met criterion under indicator 1, 10 had action plans that were likely to lead to the accomplishment of the goal. This was very good to see and these were:

- Individual #111's action plans to support her work/day goal.
- Individual #37's action plans to support his recreation and work/day goals.

- Individual #156's action plans to support her relationship goal.
- Individual #153's leisure/recreation goal, work/day goal, and greater independence goal.
- Individual #15's recreation/leisure goal.
- Individual #32's recreation/leisure goal and relationship goal.

Examples of action plans that did not support achievement of the goal included:

- Individual #111's action plans to support her relationship goal to establish a relationship with her brother did not clearly support accomplishment of her goal. She just had one action plan to attend a provider fair to support her goal to live in a group home close to her family.
- Individual #37's action plan to support his day goal was a restatement of the goal without breaking down task that would need to be completed to accomplish his goal.
- Individual #153's IDT recommended a SAP to support his recreation and relationships goals. SAPs were not developed to ensure consistent implementation.

9. Four of six ISPs integrated preferences and opportunities for choice in the individuals' ISP action plans. Individual #156 and Individual #32's ISPs did not integrate opportunities to make choices and have some control over their day.

10. ISP action plans did not comprehensively address identified strengths, needs, and barriers related to informed decision-making for five individuals. Two action plans were identified that clearly supported decision-making skills. Those were Individual #37's action plans to get his voting rights back and learn to manage his money.

11. Five individuals had action plans to support greater independence in a meaningful way. Individual #156 only had one action plan to address greater independence (to learn to purchase a DVD or CD). Her action plan was not broken down into steps that were likely to lead to greater independence.

12. IDTs did not fully integrate strategies to minimize risks in ISP action plans. Further discussion regarding the quality of strategies to reduce risks can be found throughout this report. In most cases, IDTs did not have updated assessments and data available for review prior to the ISP meeting to adequately determine risk ratings. Examples where strategies were not integrated in the ISP included:

- Individual #111's action plans to address her risk were general statements, not specific to her risks. For example her ISP noted risk related to bowel issues, but failed to note what her specific bowel issues included. Documents indicated that Individual #111 was being treated for low iron, however, the IDT had not discussed possible etiology for her low iron.
- Individual #37 did not have measurable action plans to address his recent weight gain. His risk for weight gain could have been integrated into his cooking goal, by encouraging him to choose healthy meals to cook. The team also did not address his endocrinology risk related to his psychiatric medications.
- Individual #156's action plans did not address her risk for skin issues related to her refusal to bathe and significant SIB.

13. Support needs in the areas of physical and nutritional support, communication, behavior, health (medical, nursing, pharmacy, dental), and any other adaptive needs were also not well-integrated in ISPs. In particular, psychiatry and medical supports were rarely integrated into support plans developed by other disciplines. Other examples in addition to what is above in indicator 12 included:

- Individual #111, Individual #156, Individual #15, and Individual #32 would all benefit from integrated behavior and communication strategies that might support them have more control over their day.
- Individual #32's mobility supports had not been integrated into his work goals.

14. Meaningful and substantial community integration was absent from four of six ISPs. Individual #37 and Individual #153 both had goals to attend classes at a local community college and attend counseling in the community. Individual #153 also had goals to attend church and work in the community. These goals were great to see and likely to result in meaningful integration into the community.

15. Only two of six ISPs considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. The facility offered some individuals more meaningful employment options/training based on individual preferences. For example, Individual #37 and Individual #153 were both employed on campus in various jobs that were based on preferences identified in the ISP.

- Individual #15 and Individual #111 attended day programs on the home. There were still limited program options for individuals attending day programming in the dorms and groups. Observations confirmed that many individuals still spent a majority of their day unengaged or engaged in non-functional interactions. Their options were very limited for skill building and employment was not even considered.
- Individual #156 and Individual #32 had goals to work at the sheltered workshop at the facility. Their goals, however, were generic in nature and failed to describe specific work or training based on their preferences and identified support needs.

16. One of six ISPs had substantial opportunities for functional engagement described in the ISP with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. ISPs and observations did not support that Individual #111, Individual #156, Individual #15, and Individual #32 had opportunities to spend a majority of their day engaged in functional or meaningful activities. As noted above, Individual #37 and Individual #153 were involved in various employment opportunities at the facility. Individual #153 also attended cooking classes at a local community college. Individual #37 had an action plan to attend classes at the community college, however, this action plan had not been implemented. Observations did not support that Individual #37 was meaningfully engaged for a majority of the day.

17. ISPs did not adequately address barriers to achieving goals and learning new skills.

18. Some action plans described detail about data collection and review, however, overall, ISPs did not consistently include collection of enough or the right types of data to make decisions regarding the efficacy of supports. Action plans were broadly stated and in many cases, skill acquisition plans were not developed when needed to ensure consistent training strategies were implemented.

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. Primary areas of focus are obtaining all team member recommendations for referral, and the development	Individuals:

of individualized action plans. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	156	111	37	153	15	32			
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	0/1	1/1	1/1	1/1	0/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1			
23	The determination was based on a thorough examination of living options.	50% 3/6	1/1	0/1	1/1	1/1	0/1	0/1			
24	The ISP defined a list of obstacles to referral for community placement (or the individual was referred for transition to the community).	67% 4/6	1/1	0/1	1/1	1/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	0% 0/1	N/A	N/A	N/A	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.	33% 2/6	0/1	0/1	0/1	1/1	1/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized measurable plans to educate the individual/LAR about community living options.	33% 1/3	N/A	0/1	N/A	N/A	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. The exceptions were:
    - Individual #156's ISP documented a brief history of past placements, but no description of what she liked or didn't like about past placements.
    - Individual #15's ISP noted that the IDT was unable to determine his living preferences. He had lived at the facility for many years. His ISP should reflect what staff that work closely with him know about his preferences (e.g., quiet environment, large

outdoor area).

- Individual #32's ISP did not include specific preferences related to living options, though, it was noted that he liked his current home. He has lived at El Paso SSLC since 1987; staff should be able to develop an individualized list of living preferences.

20. The Monitoring Team observed the annual ISP meeting for Individual #88. She clearly expressed her preferences as to where she wanted to live, though it was, in large part, a function of her LAR's preference.

21. None of the six ISPs fully included the opinions and recommendation of the IDT's staff members. Current assessments by key staff members were sometimes not available at the time of the ISP, but those that were present typically provided a statement of the opinion and recommendation of the respective team member. All relevant team members were often not present at annual ISP meetings to contribute to the discussion regarding supports needed in the community to address specific risks. ISPs that did not meet criterion:

- Individual #111, Individual #15, and Individual #32 had complex medical needs, however, input from their primary care physicians regarding living options was not available for team consideration.
- Input by psychiatry was missing from Individual #156 and Individual #153's ISPs. They both had complex psychiatric and behavioral risk.
- Individual #37's ISP did not include a clear statement of the IDT's recommendation, excluding input from Individual #37 and his LAR.

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

- Individual #111's ISP did not include a summary statement of the IDT's decision.
- Individual #32's statement did not include a clear rationale for not referring him to the community.

23. Three of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #111, Individual #15, and Individual #32's ISPs did not clearly define their living preferences and/or what supports could/could not be provided in the community.

24. Four 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 #111's ISP did not define specific obstacles to living in the community.
- Individual #32's IDT identified his behavior as a barrier, however, they did not describe specific behavior that would be a barrier to community placement.

25 and 27. At the ISP meeting for Individual #88, the individual's LAR was fairly adamant about not wanting to consider referral. The IDT did not create any plans to address his concerns, however, during the meeting the facility's transition specialist spoke directly to the parent, acknowledging his concerns while at the same time talking about the successes that many individuals have had and how she was available to answer questions, put him in touch with other parents and siblings whose family member had transitioned to the community.

26. Two of the six individuals (Individual #153, Individual #15) had individualized, measurable action plans to address obstacles to

referral or transition, if referred. For the most part, goals were not measurable.

28. One of three ISPs (Individual #15's) included specific action plans to educate individuals on living options. Individual #37, Individual #156, and Individual #153 had recently lived in the community and were familiar with living options. Individual #111 and Individual #32 did not have individualized goals to educate them and their LARs about living options.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.

Summary: ISPs were revised annually and developed within 30 days for new admissions. This has been the case for some time at El Paso SSLC, therefore, indicators 30 and 31 will be moved to the category of requiring less oversight. ISPs, however, were not implemented in a timely manner, and some aspects were not implemented at all. Not all IDT members participated in the important annual meeting. These other indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	156	111	37	153	15	32			
30	The ISP was revised at least annually.	100% 4/4	N/A	1/1	1/1	N/A	1/1	1/1			
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.	100% 2/2	1/1	N/A	N/A	1/1	N/A	N/A			
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	50% 3/6	0/1	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			

1. Documentation was not submitted that would support that all action plans were implemented on a timely basis for any of six ISPs. Examples in which timeliness criteria were not documented included:

- There were no data for Individual #111's greater independence or living option goals.
- Individual #37's monthly review documentation did not support implementation of his action plans for learning to cook, getting an email account, enrolling in class at the community college, or attending counseling.
- There were no data for Individual #156's action plans to begin equine therapy, purchase DVDs, or work at the workshop.

33. Three of six individuals participated in their ISP meetings. Individual #156, Individual #15, and Individual #32 did not attend their

annual ISP meetings.

34. None of the individuals had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process. QIDPs were knowledgeable regarding supports and services included in the ISP, which was good to see, however, it was not evident that all team members actively reviewed, monitored, and revised supports in a timely manner.

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

Summary: Both indicators showed some decrease in performance compared with the last review. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 156	111	37	153	15	32			
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.	33% 2/6	0/1	1/1	0/1	0/1	1/1	0/1			
36	The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

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

- The recommended assessment list was not included in Individual #37's and Individual #32's ISP preparation document.
- Individual #156 and Individual #153 were newly admitted to the facility, thus, did not have an ISP preparation meeting. As noted below, both were missing relevant assessments prior to the ISP meeting.

36. None of the IDTs arranged for and obtained needed, relevant assessments prior to the IDT meeting. Without relevant assessments available to IDTs prior to the annual ISP meeting, it was unlikely that all needed supports and services were included in the ISP. Assessments that were either not submitted or submitted late included:

- For Individual #111, QIDP assessment submission data indicated that his FSA, annual medical, habilitation therapies, nursing and behavioral health assessment were not submitted in time for team review prior to her annual ISP meeting.
- Individual #37's QIDP assessment submission data indicated that his behavioral health assessment was not submitted prior to her ISP for team review.
- Individual #156's FSA, physical, and psychiatric evaluation were completed after initial ISP meeting. PSI and vocational assessments were not adequate for determining his preferences and interest. Consequently, the IDT was unable to develop a plan for meaningful day programming.
- Individual #153's QIDP assessment submission data indicated that his nursing, dental, and nutritional assessment were not submitted 10 days prior to his ISP.
- Individual #15's behavioral health and annual medical assessment were not completed prior to his annual ISP meeting.
- Individual #32's psychiatry and behavioral health assessments were not submitted 10 days prior to his ISP date.

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.											
Summary: The need for conduct of monthly reviews was evident. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	156	111	37	153	15	32			
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 met often in response to incidents and medical issues and less frequently to review progress or revise supports and services. When recommendations were made or supports were revised, IDTs rarely met again to ensure recommendations were implemented. Reliable and valid data were often not available to guide decision-making. As noted throughout this report, little progress was made towards achieving personal goals.

For all individuals, the IDTs did not meet to discuss lack of progress and address barriers or revise supports. When additional assessments were completed during the ISP year, there was rarely documentation that the team met to discuss recommendations from the assessment or assess the efficacy of revised supports. For example,

- Individual #37's IDT requested assessments to determine his level of independence in cooking prior to developing SAPs for his cooking goal. The assessment was never completed, consequently, action plans were not developed. The QIDP did not document action taken to move forward with this assessment.
- Individual #156 had lost a significant amount of weight. Her nutritional assessment had not been updated and supports were not revised to reduce her health risks related to weight loss. On 2/9/17, her IDT met and made several recommendations including trial rollerblades, swimming, headphones, and a Disney glove (to address her SIB). The IDT did not document implementation of these recommendations or her response if implemented.
- Individual #32's IDT recommended a consultation with his PCP to discuss removing his g-tube on 1/24/17. The ISPA noted that the PNMT would update the IDT regarding this consultation. There was no documentation that this consultation had occurred.

38. Consistent implementation and monitoring of ISP action steps remained areas of concern. ISP action plans were not regularly implemented for any of the individuals. There was no evidence that IDT members were monitoring supports and services or took action when plans were not implemented.

There had been a big turnover in QIDP staff over the past year. This contributed to the inconsistency in documentation and review. For the most part when interviewed, the QIDPs were knowledgeable about supports and services included in the ISP. Going forward, the QIDPs will need to be sure that they are gathering data for the month, summarizing progress, and revising the ISP as needed.

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	37	111	15	188	32	89	46	162	10
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	0/2	0/2	0/2	1/2	0/2	0/2	0/2
Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas (i.e., Individual #37 – choking, and weight; Individual #111 – infections, and skin integrity; Individual #15 – aspiration, and fractures; Individual #188 – dental, and falls; Individual #32 – constipation/bowel obstruction, and diabetes; Individual #89 – GI problems, and urinary tract infections; Individual #46 – respiratory compromise, and circulatory; Individual #162 – GI problems, and seizures; and Individual #10 – diabetes, and skin integrity). a. It was concerning that for most risks reviewed essential clinical data were missing from the IRRFs. b. It also 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: This outcome requires individualized diagnosis-specific personal goals be created for each individual and that these goals reference/measure psychiatric indicators regarding problematic symptoms of the psychiatric disorder, as well as psychiatric indicators regarding positive pro-social behaviors. It was encouraging to see some discussion about psychiatry goals occurring during psychiatry-related meetings. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153

4	The individual has goals/objectives related to psychiatric status.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
6	The goals/objectives are based upon the individual's assessment.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

4-7. Psychiatry related goals for individuals were not integrated into the overall treatment plan. Specifically, while some goals were found in the ISP or in psychiatric clinical documentation, they were not included in the IHCP. There was a need to ensure that goals are both consistent and integrated. For example, in some documents there were two different goals documented for the same individual. This was both confusing and another example of the need for integration.

It was good to see that the facility had begun to develop goals regarding reductions in psychiatric symptoms. 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.

- To reiterate, there need to be personal goals that target the undesirable symptoms of the psychiatric disorder and that are tied to the diagnosis, and personal goals that would indicate improvement in the individual's psychiatric status.
- The goals need to be measurable, have a criterion for success, be presented to the IDT… appear in the IHCP, and be tracked/reviewed in subsequent psychiatry documents as well as be part of the QIDP's monthly review.

The psychiatric provider attended most ISP meetings. This was good to see and sets the occasion for presentation and discussion, as needed, of psychiatric indicators and psychiatry-related personal goals.

Psychiatric progress notes for quarterly clinical encounters routinely documented review of available data. There were some challenges as, in some cases, descriptions of psychiatric indicators varied depending upon the document that was being reviewed. In addition, there were some individuals where data were being collected for low frequency events. As such, these events had little bearing on the individual's day-to-day mental health functioning. Perhaps it would be more relevant to track mood or other symptoms allowing for the possible prediction of low frequency, high intensity behaviors.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.	
Summary: Indicators 12 and 13 were moved to the category of requiring less oversight after the last review. The facility should ensure that new CPEs (within the IRIS system) continue to be formatted as per Appendix B. CPEs existed for each individual, though one or more components were missing from two-thirds of them.	Individuals:

PCPs were not documenting admission IPNs as per criteria. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
12	The individual has a CPE.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
13	CPE is formatted as per Appendix B										
14	CPE content is comprehensive.	33% 3/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	0/1	0/1
15	If admitted since 1/1/14 and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/3	N/A	N/A	N/A	0/1	N/A	N/A	0/1	N/A	0/1
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.	67% 6/9	0/1	1/1	0/1	1/1	1/1	1/1	1/1	0/1	1/1

Comments:

13. The facility must ensure that newer CPEs, that is, those done in the new IRIS electronic system, meet Appendix B requirements.

14. The Monitoring Team looks for 14 components in the CPE. Three evaluations were complete and addressed all of the required elements. Six evaluations were lacking sufficient information in one to four required elements. The most common insufficient element was the bio-psycho-social formulation.

15. For the three individuals admitted since 1/1/14, a CPE was completed within 30 days of admission. None of the three admissions had an IPN authored by the primary care provider documenting the admission assessment completed within the first business day. In the case of Individual #153, the review was complicated by the fact that although he was first admitted to the facility in 2014, he transitioned to the community and was readmitted in 2016. When reviewing the initial assessment, the CPE was performed within the required 30 days. Data regarding IPNs for the initial admission were not provided. For the readmission, following transition to the community, there was a nursing assessment documented on the day of admission, however, the medical assessment was not completed until 15 days after admission and there was no documentation of a new CPE.

16. There were three individuals whose documentation revealed inconsistent diagnoses: Individual #37, Individual #60, and Individual #161.

Outcome 5 – Individuals' status and treatment are reviewed annually.	
Summary: Indicator 17 was placed into the category of requiring less oversight after the last review. Content of the annual document needed attention to include	Individuals:

all of the required components. There was improvement in the number of annual ISP meetings that the psychiatrist attended. The final ISP document, however, did not reflect the psychiatrist's participation. These four indicators will remain in active monitoring.											
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
18	Documentation prepared by psychiatry for the annual ISP was complete (e.g., annual psychiatry CPE update, PMTP).	14% 1/7	0/1	0/1	0/1	N/A	0/1	1/1	N/A	0/1	0/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	67% 6/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	89% 8/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

17. The Monitoring Team found that some individuals did not have an annual treatment update document.

18. The Monitoring Team scores 16 aspects of the annual evaluation document. One of the evaluations reviewed met full criteria. The remaining evaluations were lacking sufficient information in one to four of the required elements. The most common deficiencies were regarding the derivation of symptoms, risk versus benefit discussion, and past pharmacotherapy.

20. The psychiatrist or a member of the psychiatric team attended eight of the ISP meetings. This was good to see and was an improvement from past reviews.

21. There was a need for improvement with regard to the consistent 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. There were examples where some of the required items were included, specifically, there were two examples that included detailed reviews of medication side effects, non-pharmacological interventions were mentioned briefly and some data were reviewed. This was good to see.

Outcome 6 – Individuals who can benefit from a psychiatric support plan, have a complete psychiatric support plan developed.	
Summary: If PSPs are to be used, they need to meet the criteria for content. For one individual, a PBSP should be considered instead of a PSP. This indicator will remain	Individuals:

in active monitoring.											
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
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	N/A	N/A	N/A	0/1	N/A

Comments:
22. Two individuals, Individual #60 and Individual #37 had psychiatric support plans. The plan regarding Individual #37 did not specifically describe mood symptoms that staff were to monitor. Given the difficulties that this individual experienced and continued to experience, a PBSP may be more appropriate, allowing for consistent monitoring of mood symptoms to allow for the identification of antecedents to low frequency, high intensity behaviors, such as suicide threats or the swallowing of nonedible items. The plan regarding Individual #60, instructed staff to monitor depressive symptoms, but the symptoms were not defined.

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

Summary: Performance was about the same as last time. That is, three indicators showed improvement, one showed decrease, and one (30) remained at zero. The facility had put some efforts into improving the consent process and with continued focus, improvement should be evident at the next review. These five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	67% 6/9	0/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
29. Six examples included adequate medication side effect information.

30. The risk versus benefit discussion was not included in the consent form.

31. In seven examples, there were individualized alternate and non-pharmacological interventions included.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Scores for these indicators were about the same as last time. El Paso SSLC continues to make progress in ensuring that all individuals who need a PBSP have a PBSP. It was good to see that some individuals had PBSP data that were reliable. More attention is needed to the details of these indicators if further progress is to occur. All five will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
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	1/1	1/1	1/1	1/1	0/1	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.	72% 5/7	1/1	0/1	N/A	1/1	1/1	1/1	0/1	N/A	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 5/5	1/1	N/A	N/A	1/1	1/1	1/1	N/A	N/A	1/1
4	The goals/objectives were based upon the individual's assessments.	80% 4/5	1/1	N/A	N/A	0/1	1/1	1/1	N/A	N/A	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	43% 3/7	1/1	1/1	N/A	0/1	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 (eight individuals reviewed by the behavioral health Monitoring Team and three individuals reviewed by the physical health Monitoring Team). Ten of those 11 individuals had PBSPs. The exception was Individual #37. He did not have a PBSP at the time of the onsite review. He engaged in low rates of the ingestion of inedible objects that placed him at risk and, therefore, warranted a PBSP. Moreover, these behaviors resulted, in part, in his failed community residential placement (2013) and more recently failed community employment (2016).

There were a number of individuals at El Paso SSLC with histories, and current exhibitions, of complex challenging behavior disorders. The facility might benefit from additional behavior analyst consultation in the development and modification of their behavioral treatment programs.

2. Individual #179 had no behavioral objectives after July 2016, and Individual #159 had no behavioral objectives.

4. Individual #156's January 2017 progress note included an objective to reduce elopement, however, elopement was not reviewed in her functional assessment

5. Individual #161, Individual #179, and Individual #112 had interobserver agreement (IOA) and data collection timeliness (DCT) assessments in the last six months that were at or above 80%, indicating that their PBSP data were reliable. Individual #156, Individual #159, and Individual #153 did not have IOA or DCT measures in the last six months. Individual #111 had a IOA and DCT assessment on 10/16/17, however, her DCT was 0%.

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.

Moreover, this is a key pivotal item/indicator. Reliable data is the foundation upon which many other indicators rely. For instance, you can't confidently determine if progress has occurred if you don't have data you can rely upon.

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

All individuals had current behavioral health and functional assessments (indicators 10 and 11). This was an improvement from the last review and with sustained high performance, these indicators might move to the category of requiring less oversight after the next review. More attention needs to be paid to the content of the functional assessments (indicator 12). All three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
10	The individual has a current, and complete annual behavioral health update.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The functional assessment is current (within the past 12 months).	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1
12	The functional assessment is complete.	43% 3/7	1/1	0/1	N/A	1/1	0/1	0/1	0/1	N/A	1/1

Comments:
10-11. Criteria were met for all individuals for both of these indicators.

12. Individual #161, Individual #156, and Individual #153 had complete functional assessments. Individual #179, Individual #112, and Individual #111's functional assessments were rated incomplete because antecedent events were not included for all target behaviors, and there was no clear summary based on the hypothesized antecedent and consequent conditions that affect the target behaviors.

Overall, Individual #159's functional assessment was very good, however, it did not have a clear summary statement and, therefore, was rated as incomplete. 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: It was good to see that PBSPs were current and with sustained high performance this indicator (14) might move to the category of requiring less oversight after the next review. More attention to implementation timeliness and content of PBSPs is required for indicators 13 and 15 to show more progress. All three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	57% 4/7	1/1	1/1	N/A	1/1	0/1	0/1	0/1	N/A	1/1
14	The PBSP was current (within the past 12 months).	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	29% 2/7	1/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	1/1

Comments:

13. There was documentation that Individual #161, Individual #179, Individual #156, and Individual #153's PBSPs were implemented within 14 days of attaining all necessary consents/approvals.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Individual #153 and Individual #161's PBSPs were rated as containing all of these components. Individual #156 and Individual #111's PBSPs were 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 #179's PBSP did not appear to be based on the results of the hypothesized function of his target behaviors. Individual #112 and Individual #159's PBSPs had insufficient antecedent and/or consequent strategies to reduce 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: Accessing outside counseling for individuals at El Paso SSLC took a long time and for some individuals, was still not available. These indicators will remain

Individuals:

in active monitoring.											
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	1/1
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 24. Individual #153 and Individual #37's IDTs referred them for counseling. At the time of the onsite review, there was documentation that Individual #153 was receiving counseling. There was, however, no evidence that Individual #37 was receiving counseling. 25. Individual #153 was receiving counseling in the community and, therefore, this indicator was not scored for him.											

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Indicator c will continue under active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.										
c.	Individual has timely periodic medical reviews, based on their individualized needs, but no less than every six months	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
Comments: c. The medical audit tool states: "Based on individuals' medical diagnoses and at-risk conditions, their ISPs/IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines." Interval reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interval reviews will need to occur more frequently. The IHCPs reviewed did not define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.											

Outcome 3 – Individuals receive quality routine medical assessments and care.	
Summary: With regard to the quality of medical assessments, the Center should focus on improving the quality of plans of care. Although Indicator b was moved to	Individuals:

the category requiring less oversight, in reviewing individuals' annual medical assessments, the Monitoring Team noted that at times PCPs did not use up-to-date diagnostic terms, and one individual's diagnosis was not justified. If such issues are not corrected, then Indicator b might move back to active monitoring at the time of the next review.											
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	Individual receives quality AMA.	33% 3/9	0/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that three individuals' AMAs (i.e., Individual #15, Individual #32, and Individual #46) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed 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. Most, but not all included pre-natal histories, family history, childhood illnesses, and updated active problem lists. Moving forward, the Medical Department should focus on ensuring medical assessments include plans of care for each active medical problem, when appropriate.

The primary medical providers did not complete the annual medical assessments, but rather a physician consultant, who worked several days each week at the Center, completed them. Therefore, the physician who provides care to the individuals and/or participates in the ISP meetings did not develop the assessment and medical plan of care, which is an essential component of the AMA. In other words, one physician outlines the plan of medical care, and the expectation is that another physician will convey this plan to the IDT and implement the plan.

The medical plans of care were frequently vague and lacked sufficient information. They often stated continue medication or follow-up with internal medicine, etc. Additionally, the AMAs often included data that could not be explained by reading the document. For example, if a male has mammography (i.e., Individual #15), there should be some explanation for conducting this study.

b. Although Indicator b was moved to the category requiring less oversight, in reviewing individuals' annual medical assessments, the Monitoring Team noted that at times PCPs did not use up-to-date diagnostic terms (e.g., essential hypertension instead of the current diagnosis of primary hypertension, renal insufficiency instead of the term chronic kidney disease, borderline diabetes instead of pre-diabetes). In addition, it was not clear that the diagnosis of iron deficiency for Individual #162 was justified. If such issues are not corrected, then Indicator b might move back to active monitoring at the time of the next review.

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

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

Summary: Much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs. Defining the frequency of medical review in alignment with current standards of practice, and accepted clinical pathways/guidelines to address individuals' chronic and at-risk conditions is a necessary component of IHCPs.

#	Indicator	Overall Score	Individuals: 37	111	15	188	32	89	46	162	10
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.	22% 4/18	0/2	0/2	0/2	2/2	0/2	0/2	1/2	0/2	1/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	11% 2/18	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2	0/2

Comments: a. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #37 – other: thrombocytopenia, and other: Vitamin D deficiency; Individual #111 – osteoporosis, and cardiac disease; Individual #15 – cardiac disease, and other: renal disease; Individual #188 – diabetes, and cardiac disease; Individual #32 – diabetes, and infections; Individual #89 – diabetes, and osteoporosis; Individual #46 – other: hypertension, and diabetes; Individual #162 – gastrointestinal (GI) problems, and other: hypothyroidism; and Individual #10 – diabetes, and osteoporosis].

The IHCPs that sufficiently addressed individuals' chronic or at-risk condition in accordance with current standards of practice were for: Individual #188 – diabetes, and cardiac disease, Individual #46 – other: hypertension, and Individual #10 – osteoporosis.

b. The IHCPs that defined the frequency of medical review based on current standards of practice were for: Individual #188 –cardiac disease, and Individual #46 – other: hypertension.

Dental

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

Summary: The Center did not provide annual dental examinations for any of the individuals reviewed. The Center should continue to focus on the quality of dental summaries. Given that the Center did not provide annual dental examination

Individuals:

documentation, Indicator a will move back into active monitoring.											
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	Individual receives timely dental examination and summary:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight. Given that the Center did not provide dental examination documentation, Indicator a will move back into active monitoring.									
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.										
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days.										
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.										
b.	Individual receives a comprehensive dental examination.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	25% 2/8	0/1	0/1	0/1	0/1	0/1	N/R	0/1	1/1	1/1

Comments: b. It was concerning that the Center did not provide annual dental examinations for any of the individuals reviewed. No explanation was offered. The Center utilizes a part-time dentist for approximately 10 days per month.

c. It was good to see that Individual #162 and Individual #10 had dental summaries that met criteria. Individual #10 was edentulous. On a positive note, all of the dental summaries included the following:

- Recommendations related to the need for desensitization or another plan;
- Provision of written oral hygiene instructions;
- Dental care recommendations; and
- Treatment plan, including the recall frequency.

Most included:

- 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; and
- Recommendations for the risk level for the IRRF.

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

- Identification of dental conditions that adversely affect systemic health; and
- A description of the treatment provided.

Nursing

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

Summary: The Center should focus on ensuring nurses complete timely and complete quarterly reviews and physical assessments, nurses complete quality annual nursing assessments, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice. The remaining indicators will continue in active monitoring.			Individuals:									
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	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.										
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	11% 1/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	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.	8% 1/13	0/2	0/1	0/2	1/1	0/1	N/A	0/2	0/2	0/2

Comments: a.iii. As part of quarterly reviews, full physical assessments were not documented for a number of individuals.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #37 – choking, and weight; Individual #111 – infections, and skin integrity; Individual #15 – aspiration, and fractures; Individual #188 – dental, and falls; Individual #32 – constipation/bowel obstruction, and diabetes; Individual #89 – GI problems, and urinary tract infections; Individual #46 – respiratory compromise, and circulatory; Individual #162 – GI problems, and seizures; and Individual #10 – diabetes, 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.

The following provide just a few examples of many concerns noted:

- For Individual #10, the summary in the annual nursing assessment contained chronological dates of events related to his diabetes, and other lab information, as well as a summary of orders. It indicated that he was experiencing episodes of hyperglycemia and hypoglycemia. However, no analysis was included comparing the current status of his hyper/hypo-glycemic events to the previous quarter/year, changes in medications, and whether or not he was responding to the medication changes, positively or negatively. One recommendation noted that prior to physical activity, blood glucose levels and oxygen levels should be assessed. No recommendations were offered regarding regular nursing assessments, or other proactive interventions to assist Individual #10 in gaining better control of his health.
- With regard to Individual #162's GI problems, his annual nursing assessment did not recommend substantive preventive measures to minimize the occurrences of his tube dislodgement. It offered no review of his medication side effects, and/or whether or not he had had any reflux episodes, coughing, etc. The assessment provided no health-related recommendation to minimize the at-risk condition.
- For Individual #89, the annual nursing assessment offered no analysis of his risk for urinary tract infections. The IRRF stated there were four incidents last year, but the nursing assessment did not mention these events. Although the assessment included a recommendation that he would continue with Enhanced Infection Control Measures/Precautions at all times to prevent infections, it was unclear what this meant.
- Individual #188's annual nursing assessment did not provide an analysis of her falls, what her fall score had been, or if she had supports in place to prevent falls. The assessment did not offer recommendations related to preventing falls.
- For Individual #111, the annual nursing assessment did not include a comparative review from the previous quarter or year in relation to her significant infections, including reoccurring Methicillin-resistant Staphylococcus aureus (MRSA), an abdominal wound, Vancomycin-resistant Enterococcus (VRE) at the G-tube site, and C-Diff twice (i.e., in the hospital and at the Center, the latter occurring on 9/13/16) and other identified organisms or their site. It also did not offer recommendations for the frequency of ongoing nursing assessments related to her infection risk.
- For Individual #37's choking, the nursing assessment's analysis of health risks did not include a review of the number of events of ingesting non-edible objects, being placed on stool watch, previous x-ray findings, etc. The recommendations merely stated: Offer counseling in conjunction with medication therapy, and encourage to put sunscreen on daily and as needed before stepping outdoors in the a.m. and p.m. None of the recommendations addressed his choking risk.

c. For numerous changes of status, concerns were noted related to nursing assessments in accordance with nursing protocols or current standards of practice.

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 four review periods, the Center's scores have been low for these indicators, this is an area that requires focused efforts. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall	37	111	15	188	32	89	46	162	10

		Score									
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. Substantial work was needed to improve IHCPs to include nursing interventions.											

Physical and Nutritional Management

Outcome 2 – Individuals at high risk for physical and nutritional management (PNM) concerns receive timely and quality PNMT reviews that accurately identify individuals' needs for PNM supports.											
Summary: It was positive that individuals' IDTs generally referred them to the PNMT within five days of a qualifying event, and the PNMT completed a review within five days of the referral. With sustained performance in these areas, after the next review, Indicators a and b might move to the category requiring less oversight. It also was positive that as needed, a Registered Nurse (RN) Post-Hospitalization Review was generally completed for the individuals reviewed, and the PNMT discussed the results. The Center should focus on sustaining its progress in this area, as well as completing PNMT comprehensive assessments for individuals needing them. In doing so, the Center should conduct quality PNMT comprehensive assessments that fully address the components detailed in the audit tool.			Individuals:							
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10

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% 5/5	N/A	1/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	80% 4/5		1/1	0/1		1/1	1/1	N/A	N/A	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/4		N/A	0/1		0/1	0/1	N/A	N/A	0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	20% 1/5		1/1	0/1		0/1	0/1	N/A	N/A	0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	83% 5/6		1/1	1/1		0/1	N/A	1/1	1/1	1/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	33% 2/6		1/1	0/1		0/1	0/1	1/1	N/A	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	100% 1/1		1/1	N/A		N/A	N/A	N/A	N/A	N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/4		N/A	0/1		0/1	0/1	N/A	N/A	0/1

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

- Individual #111 had a lengthy hospitalization for hernia repair and sepsis (i.e., from 4/6/16 to 6/24/16), and then was admitted to a long-term acute care (LTAC) facility (i.e., from 6/24/16 to 8/29/16) to manage an open abdominal wound and Klebsiella pneumoniae. During her admission to the LTAC, she was diagnosed with aspiration pneumonia. Evidence was found of ongoing PNMT review during her hospitalization, as far back as 4/13/16. The PNMT appeared to be very aware of her status throughout this time. On 8/31/16, the PNMT conducted a review, but determined that a comprehensive assessment was not indicated. The PNMT's rationale was that it was time for her annual ISP meeting, and they were going to give the IDT an opportunity to complete comprehensive assessments, and then, the PNMT would review her again in three months. This appeared to be a reasonable approach.
- On 10/1/16, Individual #15 experienced his fourth femur fracture. This was a discovered injury, the circumstances around which were unclear. In December 2016, he also had aspiration pneumonitis. The PNMT should have, but did not conduct a

comprehensive assessment. Their rationale was that he had sufficient supports in place, and that his osteoporosis was so bad that he was likely to have fracture despite adherence to the PNMP and other plans. Part of the problem appeared to be that the clinicians on his IDT were also the PNMT clinicians. As a result, it was difficult to obtain an assessment that was the second opinion type assessment that PNMTs provide when this is not the case.

- On 10/5/16, Individual #32 fell sustaining a serious injury, including a head injury. On 10/11/16, he was diagnosed with hospital-acquired aspiration pneumonia (ventilator associated), and on 12/21/16, he had a feeding tube placed. Although he subsequently returned to oral eating, the PNMT should have conducted a comprehensive assessment, but did not. On 12/2/16, after his discharge on 12/1/16, the RN completed a post-hospitalization review. It was not clear that the PNMT reviewed these findings.
- It appeared that on 2/10/17, the PNMT discharged Individual #89, after assessing him due to aspiration pneumonia. However, in response to the Monitoring Team's document request, the Center did not submit the PNMT assessment that appeared was completed in March 2016. As such, it was not considered for this review.
- In 2015, Individual #46's qualifying event related to recurring decubitus ulcers resulted in a referral. The PNMT followed her through 4/13/16, and then discharged her to the IDT. Her health issues and hospitalizations followed one after the other, and did not provide an opportunity for the PNMT to conduct a comprehensive assessment. However, the PNMT did continually review her status during that time period. On 12/30/16, she died.
- For Individual #162, the Center submitted evidence of PNMT RN post-hospitalization reviews and PNMT review. Based on this documentation, there was no indication for further PNMT review or assessment.
- The PNMT should have, but did not assess Individual #10 related to two diagnoses of aspiration pneumonia as well as weight loss. More specifically, on 9/19/16, he was diagnosed with aspiration pneumonia, likely after emesis, and was hospitalized from 9/19/16 to 9/26/16. Since 1/13/16, the PNMT followed him routinely related to his weight loss, but the PNMT did not complete an assessment, even after the aspiration pneumonia diagnosis for which they conducted a review only on 9/28/16. On 11/21/16, Individual #10 had a second diagnosis of aspiration pneumonia, and again, the PNMT only conducted a review. Subsequently, he had weight loss of 5.88% in 30 days, and a decubitus ulcer (Stage 1) on his left buttock, but still the PNMT did not conduct an assessment, but rather completed a review only.

h. As noted above, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #15, Individual #32, and Individual #10), and the Center did not submit the comprehensive assessment for Individual #89.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Some improvement was noted with regard to the quality of individuals' PNMPs and Dining Plans. The Center should continue to focus on improving the component that addresses individuals' communication skills, including describing how others should communicate with the individual. However, overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. All of these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10

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).	18% 3/17	0/1	0/2	0/2	0/2	0/2	0/2	2/2	1/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	24% 4/17	0/1	0/2	0/2	1/2	0/2	0/2	2/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	50% 4/8	N/A	1/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	0% 0/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/17	0/1	0/2	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.	6% 1/17	0/1	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	29% 5/17	0/1	1/2	0/2	1/2	0/2	0/2	2/2	1/2	0/2

Comments: The Monitoring Team reviewed 17 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: weight for Individual #37; falls, and aspiration for Individual #111; aspiration, and fractures for Individual #15; choking, and falls for Individual #188; falls, and weight for Individual #32; aspiration, and fractures for Individual #89; fractures, and skin integrity for Individual #46; aspiration, and falls for Individual #162; and skin integrity, and aspiration for Individual #10.

a. and b. Overall, ISPs/IHCPs reviewed did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP, and/or include preventative physical and nutritional management interventions to minimize the individuals' risks. The exceptions were the IHCPs for fractures, and skin integrity for Individual #46; and falls for Individual #162. The IHCP for falls for Individual #188 also included sufficient preventative interventions.

c. Individual #37 did not have, and did not appear to require a PNMP or Dining Plan. The remaining individuals reviewed had PNMPs and/or Dining Plans. The PNMPs for Individual #15, Individual #188, Individual #32, and Individual #162 did not describe how others should communicate with the individual. The Center should focus on this component of the PNMPs.

f. The IHCP that identified triggers and actions to take was for falls for Individual #188.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. The exceptions were: aspiration for Individual #111; falls for Individual #188; fractures, and skin integrity for Individual #46; and falls for Individual #162.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	20% 1/5	N/A	N/A	0/1	N/A	1/1	N/A	0/1	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% 0/4			0/1		0/1		N/A	0/1	0/1
Comments: a. and b. The following provide some examples of concerns noted: • At times, IDTs indicated that the "risks outweigh the benefits" without describing the risks and benefits, and/or documenting the IDT deliberations. Specific medical necessity for the enteral nutrition was not stated. • In other instances, IDTs identified issues that potentially could be addressed (e.g., tactile defensiveness, or not being able to handle specific food textures), but then the IDT did not define a plan to address the issue or identify a possible alternative(s).											

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: As noted in the last report, El Paso SSLC made improvements with regard to the quality of OT/PT assessments, and this progress continued, which was good to see. 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. However, with sustained performance, after the next review, Indicator b might move to the category requiring less oversight. For now, all of these indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	N/A									

	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	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.	67% 6/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	89% 8/9	1/1	0/1	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, 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.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/2	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	71% 5/7	1/1	N/A	1/1	0/1	1/1	0/1	1/1	1/1	N/A
Comments: a. and b. Six of the nine individuals reviewed received timely OT/PT assessments and/or reassessments based on changes of status. Care needs to be taken to ensure that holidays are taken into consideration when determining due dates for annual assessments. Individual #111 had a lengthy hospitalization for hernia repair and sepsis (i.e., from 4/6/16 to 6/24/16), and then was admitted to a long-term acute care (LTAC) facility (i.e., from 6/24/16 to 8/29/16). Despite this significant change of status, it was not until 9/29/16, a month after her return, that the OT/PT completed a comprehensive assessment. Even though direct therapy was initiated, no										

evidence was found of a thorough, post-hospitalization OT/PT assessment.

d. and e. The Monitoring Team reviewed comprehensive OT/PT assessments for two individuals, and updates for seven individuals. Improvement continued to be noted, which was good to see. During this review, some of the assessments reviewed were very strong, and included information necessary to address individuals' strengths, needs, and preferences. To continue down the path of improvement, Center clinicians are encouraged to use the audit tool as a checklist as they complete their assessments, and to focus on the following areas that were identified as problematic in assessments or updates that did not meet criteria:

- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale): If adaptive equipment is noted to be in fair or poor condition, the assessor should provide a rationale for why the equipment continues to meet the individual's needs, and identify what would constitute a need for replacement; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: It is important to ensure that when assessments identify needs that they offer corresponding recommendations. For example, if an individual has been participating in direct therapy, then recommendations should address whether or not to continue it based on specific data, and whether current goal/objectives remain appropriate or should be modified with a rationale. For an individual with increasing falls, the OT/PT assessment should recommend strategies, including, for example, collaboration with other disciplines (e.g., medical, behavioral health services), as needed.

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: The Center's scores with these indicators have varied. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	11% 1/9	0/1	0/1	0/1	1/1	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.	63% 5/8	N/A	0/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	25% 1/4	N/A	0/1	0/1	0/1	N/A	1/1	N/A	N/A	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to	80% 4/5	N/A	0/1	1/1	N/A	1/1	1/1	N/A	N/A	1/1

	discuss and approve implementation.										

Comments: b. For three individuals, comments in ISPs related to PNMP approval or changes were incomplete and/or did not provide sufficient detail or justifications/rationales for proposed changes.

c. and d. Examples included:

- For a number of individuals for whom direct therapy was initiated after an ISP meeting, it was good to see that IDTs held ISPA meetings to review and accept the therapy plans.
- For Individual #111, no assessment was found to justify the initiation of direct therapy, and no ISPA meeting documentation was found to show that the PT presented assessment results or a therapy plan to the IDT for approval. Moreover, the assessment completed for her annual ISP meeting did not review data collected as a result of the direct therapy, and/or recommend continuation or modification to the current goals/objectives.

Communication

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

Summary: Although more work was needed, some improvement was seen with regard to communication assessments and updates. The Center should focus on completing timely assessments, and continuing to improve the quality of assessments and updates.

#	Indicator	Overall Score	Individuals: 37	111	15	188	32	89	46	162	10
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.	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.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	67% 6/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									

c.	Individual receives quality screening. Individual's screening discusses to the depth and complexity necessary, the following: • Pertinent diagnoses, if known at admission for newly-admitted individuals; • Functional expressive (i.e., verbal and nonverbal) and receptive skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Assistive/augmentative devices and supports; • Discussion of medications being taken with a known impact on communication; • Communication needs [including alternative and augmentative communication (AAC), Environmental Control (EC) or language-based]; and • Recommendations, including need for assessment.	N/A									
d.	Individual receives quality Comprehensive Assessment.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	38% 3/8	1/1	0/1	0/1	0/1	0/1	1/1	0/1	1/1	N/A

Comments: d. In 2014, Individual #10 was assessed for and provided a hearing aid, but he refused to wear it. There was no indication that this had been revisited since that time, and his comprehensive communication assessment did not discuss potential strategies to build his tolerance to the hearing aid.

e. It was positive that the communication assessments for Individual #162, Individual #89, and Individual #37 contained all of the necessary components and addressed the individuals' strengths, needs, and preferences. The following provides examples of concerns noted with regard to the required components of the communication updates for the remaining individuals:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication: Individual #111's assessment did not address this component;
- The individual's preferences and strengths are used in the development of communication supports and services: The preference included in Individual #89's was limited to playing music. Individual #111's update did not discuss her strengths and preferences in relation to communication supports or her ability to participate;
- The effectiveness of current supports, including monitoring findings: Individual #188's communication assessment indicated that when she screamed, staff provided her with alternative food or activity choices, or left her alone. This pattern was described as atypical and not appropriate, but effective. The only reason that this mode of communication was effective was because staff gave Individual #188 what they thought she wanted when she engaged in challenging behavior. This would not be effective in other settings, and the assessor should not have viewed it as an effective mode of communication. Moreover, during the onsite review, Monitoring Team members observed Individual #188 sitting outside alone in the dirt screaming and

yelling;

- Assessment of communication needs (including AAC, EC, or language-based) in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services: Most updates reviewed included insufficient assessment of individuals' communication needs (e.g., Individual #89, Individual #188, and Individual #46), and/or justification for not recommending communication supports (e.g., Individual #111, and Individual #32); 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: A number of the updates did not address identified needs through recommendations, and/or did not contain sufficient assessment information to determine whether or not recommendations were needed.

On a positive note, all of the updates sufficiently addressed the following:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- A description of any changes within the last year related to functional expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or development of the individual's current communication abilities/skills.

Outcome 3 – Individuals who would benefit from AAC, EC, or language-based supports and services have ISPs that describe how the individuals communicate, and include plans or strategies to meet their needs.

Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	43% 3/7	N/A	0/1	0/1	1/1	0/1	1/1	1/1	0/1	N/A
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	22% 2/9	N/A	0/1	1/1	0/1	1/1	0/2	0/1	0/1	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.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A
Comments: a. Unfortunately, for a number of individuals (e.g., Individual #37, Individual #111, Individual #188, Individual #46, and											

Individual #10), their communication assessments included good descriptions of how they communicate and how staff should communicate with them, but these descriptions were not carried into their ISPs.

Skill Acquisition and Engagement

Outcome 1 - All individuals have goals/objectives for skill acquisition that are measurable, based upon assessments, and designed to improve independence and quality of life.

Summary: All individuals had SAPs, though given the many needs of the individuals, there were very few SAPs created for them. Almost all individuals had two or less SAPs. That being said, about half of the SAPs that were created were measurable, based on assessments, practical, functional, and meaningful. This partial success should be built upon. The absence of reliable data to be able to determine progress, however, was missing from all SAPs. All five indicators will remain in active monitoring. The new SAP plan (begun in April 2017), however, looked to address many of the issues with the current SAPs. The group assigned to this task was motivated and the Monitoring Team shares the facility's optimism in seeing improvements at the next monitoring review.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
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.	56% 9/16	1/2	0/1	1/1	1/1	0/1	2/3	3/3	1/2	0/2
3	The individual's SAPs were based on assessment results.	75% 12/16	2/2	1/1	0/1	1/1	1/1	3/3	2/3	1/2	1/2
4	SAPs are practical, functional, and meaningful.	50% 8/16	0/2	1/1	0/1	1/1	1/1	3/3	2/3	0/2	0/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/16	0/2	0/1	0/1	0/1	0/1	0/3	0/3	0/2	0/2

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There was one SAP available to review for Individual #179, Individual #60, Individual #156, and Individual #111, two SAPs available for Individual #161, Individual #37, and Individual #153, and three SAPs for Individual #112 and Individual #159, for a total of 16 SAPs for this review.

2. The majority of SAPs were measurable. Many SAPs, however, did not indicate the objective's prompt level (e.g., Individual #37's applying tear drops SAP) and, therefore, were not measurable.

3. Seventy-five percent of the SAPs were based on assessment results. Several SAP assessments, however, did not indicate what assessments were completed to determine why these SAPs were chosen (e.g., Individual #60's point to her medication SAP).

4. Fifty percent of the SAPs were judged to be practical and functional (e.g., Individual #156's choose pictures from her communication book SAP). Several SAPs, however, were judged not to be practical or functional because they represented a compliance issue rather than a new skill (e.g., Individual #37's identify money amounts from items in a catalog SAP).

5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The Monitoring Team was encouraged to learn that El Paso SSLC began collecting IOA in Nov 2016.

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 and had been so for this review and the previous two reviews, too. Therefore, this indicator (10) will be moved to the category of requiring less oversight. In order for these assessments to be useful to the IDT, they need to be made available to the IDT prior to the annual meeting, as required. Indicators 11 and 12 will remain in active monitoring, though with sustained high performance, indicator 12 might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 161	179	60	156	111	112	159	37	153
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.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	89% 8/9	1/1	1/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1

Comments:

10. All individuals had current FSAs, PSIs, and vocational assessments.

11. No individual's FSAs, PSIs, and vocational assessments were available to the IDT at lease 10 days prior to the ISP. While all individuals had timely vocational assessments, several individual's PSIs (e.g., Individual #37) and/or FSAs (e.g., Individual #60) were not available to the IDT at least 10 days prior to their ISP.

12. Only Individual #111's assessment 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. At the last review, 19 of these indicators were moved to the category of requiring less oversight (in psychiatry, medical, pharmacy, dental, and OT/PT). For this review, six other indicators were added to this category, in psychiatry and dental, including one full outcome: psychiatry outcome 8. In pharmacy, however, five indicators of outcome 2 regarding QDRRs were moved back to the category of active monitoring.

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

Goals/Objectives and Review of Progress

Overall, without clinically relevant, measurable goals/objectives, IDTs could not measure progress with regard to individuals' physical and/or dental health. In addition, 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.

Regarding more than three restraints in any rolling 30-day period, the required content of reviews was not occurring.

Psychiatric medication side effect assessments were not routinely occurring in a timely manner. Polypharmacy designation, review, and committee, however, were regularly functioning parts of the psychiatry program.

Data presentation was occurring during clinical meetings and peer review and progress notes (indicator 19) commented on the individual's status. Graphing and internal peer review requirements need some attention.

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 providers' assessment and follow-up on acute issues treated at the Center and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. In fact, in comparison with the previous review, for most related indicators, the Center's performance decreased.

In psychiatry, without measurable goals, progress could not be determined. But, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals.

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. Moreover, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs did include in IHCPs/ISPs.

In many instances, individuals with chronic conditions or at high or medium risk for health issues did not receive medical assessment, tests, and evaluations consistent with current standards of care, and/or PCPs had not identified the necessary treatment(s), interventions, and strategies, as appropriate, to ensure amelioration of the chronic or at-risk condition to the extent possible. These are essential components to ensuring the Center provides individuals with adequate medical care.

The Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. IPNs related to consultations should document the provider's rationale for making a referral or not making a referral to the IDT.

The Center should 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.

It was of significant concern that the Center had not provided needed dental care to a number of individuals reviewed, including prophylactic care, x-rays, fluoride application, treatment for periodontal disease, and/or restorative work. Moreover, the Center did not provide annual dental exam documentation for any of the individuals reviewed. As a result, the indicator related to the timeliness of dental exams will move back to active oversight. The Center needs to focus on the provision and quality of dental treatment.

On a positive note, for four reviews, individuals reviewed who needed suction tooth brushing received it according to the schedule in their ISPs. So, the related indicator will move to the category requiring less oversight.

At the time of the last review, due to previous high performance with regard to the completion of quality Quarterly Drug Regimen Reviews (QDRRs), the related indicator was moved to the category requiring less oversight. However, based on the use of the QDRRs for other elements of the Monitoring Team's review, problems were noted with regard to the Pharmacist noting all relevant lab values, and addressing irregularities through recommendations to prescribers. As a result, the related indicator will move back to active monitoring. It was good to see improvement with regard to implementation of the agreed-upon recommendations.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (35% of 37 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. On a positive note, when the Monitoring Team observed staff assisting individuals with transfers, the staff followed the PNMPs. However, positioning was of significant concern (i.e., 70% of individuals observed were not positioned correctly), and dining plan implementation remained a concern (i.e., staff did not follow Dining Plans during 27% of observations). 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 psychiatrist was an active participant in the development, and ongoing discussion, of the PBSPs. Psychiatry and neurology collaboration occurred as per criteria for these indicators and had been so for some time. The content, style, and quarterly occurrence of the psychiatric clinics had improved since the last review. Some required components were missing from each review's documentation. Psychiatry documentation prior to the implementation of the electronic record was better than it was in the electronic format at the time of this review. The psychiatry department could probably use some help in this regard.

In behavioral health, one individual (who had reliable data) was making progress. Goals were not updated based upon progress or lack of progress.

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: Almost all of these indicators decreased in scoring since the last review. More importantly, the required content of reviews when more than three crisis intervention restraints occurred within any rolling 30-day period were not being	Individuals:

met. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	156	153							
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.	50% 1/2	0/1	1/1							
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	0% 0/2	0/1	0/1							
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1							
21	The minutes from the individual's ISPA meeting reflected: 1. a discussion of contributing environmental variables, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/2	0/1	0/1							
22	Did the minutes from the individual's ISPA meeting reflect: 1. a discussion of potential environmental antecedents, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them?	0% 0/2	0/1	0/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/2	0/1	0/1							
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	100% 2/2	1/1	1/1							
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	0% 0/1	N/A	0/1							
26	The PBSP was complete.	N/A	N/A	N/A							
27	The crisis intervention plan was complete.	0% 0/1	N/A	0/1							

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% 0/2	0/1	0/1							
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	0% 0/2	0/1	0/1							

Comments:
18-29. This outcome and its indicators applied to Individual #156 and Individual #153.

18. ISPAs to address more than three restraints in 30 days should occur within 10 business days of the fourth restraint. Individual #153 had his fourth restraint in 30 days on 12/14/16, and his ISPA met on 12/15/16 to address these restraints. Individual #156 had her fourth restraint in 30 days on 10/7/16. The IDT met on 9/12/16, 9/20/16, 10/19/16, and 11/23/16 to discuss Individual #156's restraints. None of those meetings, however, included a review of more than three restraints in 30 days, or discussed any of the issues in this provision.

19. Both Individual #156 and Individual #153's IDTs met several times to review single restraints, however, none of those meeting minutes reflected the development and evaluation of a plan to address more than three restraints in a rolling 30 days.

20-23. None of these issues were discussed in either Individual #156 or Individual #153's ISPA minutes.

25. Individual #156 did not have a CIP, however, her four restraints occurred during the first two months of her admission to El Paso SSLC, and were scored as N/A because they appeared to represent an isolated event. Individual #153 did not have a CIP.

27. Individual #156 was not scored for this indicator because she did not require a CIP.

28. Neither Individual #156 nor Individual #153's PBSPs had any treatment integrity measures.

29. Neither Individual #156 nor Individual #153's ISPAs indicated that their IDTs reviewed their PBSPs.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.	
Summary: Reiss screens have been conducted at El Paso SSLC for some time now. Therefore, indicator 1 will be moved to the category of requiring less oversight. For indicator 2 and 3, given the scores at the last review and N/A scores this time, both will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	15	46							
1	If not receiving psychiatric services, a Reiss was conducted.	100% 2/2	1/1	1/1							
2	If a change of status occurred, and if not already receiving psychiatric services, the individual was referred to psychiatry, or a Reiss was conducted.	N/A	N/A	N/A							
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A	N/A	N/A							

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, two individuals were not receiving psychiatric services. Individual #15 and Individual #46 were assessed utilizing the Reiss screen. Further evaluation was not necessary.

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

Summary: Without measurable goals, progress could not be determined. The Monitoring Team, however, acknowledges that, even so, when an individual was experiencing increases in psychiatric symptoms, actions were taken for all individuals. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
8	The individual is making progress and/or maintaining stability.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1

Comments:
8-9. Without measurable goals and objectives existing (and being integrated into the IHCP), 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 individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (i.e., medication adjustments) were developed and implemented.

One individual, Individual #159, was a new admission. Recommendations for revisions to the treatment plan were made, however,

because these recommendations were documented in January 2017, it was too soon to determine if these were implemented.

Outcome 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.											
Summary: The psychiatrist was an active participant in the development, and ongoing discussion, of the PBSPs. With sustained high performance, this indicator (24) might move to the category of requiring less oversight after the next review. Consistency in psychiatry/behavioral health referencing of respective disorders still needed improvement as detailed in the comments below. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
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	N/A	1/1	0/1	1/1	0/1	0/1	1/1
24	The psychiatrist participated in the development of the PBSP.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1

Comments:
23. The psychiatric documentation referenced specific behaviors that were being tracked by behavioral health. In addition, in some cases, the functional assessment included information regarding the individual's psychiatric diagnosis and included the effects of said diagnosis on the target behaviors. This was good to see.

There was a lack on consistency regarding psychiatric symptoms being monitored because, in some cases, the symptoms of a specific diagnosis noted in psychiatric documentation did not correlate with the symptoms included in the functional assessment.

24. There was documentation of the psychiatrist's review of the PBSP in the psychiatric clinical documentation. In addition, in the psychiatric clinical encounters observed during the monitoring visit, the psychiatrist asked questions and made comments regarding the PBSP.

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: Psychiatry and neurology collaboration occurred as per criteria for these indicators and had been so for some time. These three indicators will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153

25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1
26	Frequency was at least annual.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.	100% 2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A	1/1

Comments:
25-27. These indicators applied to two individuals. This facility has an established neuro/psych clinic. There is a history of consistent consultation and collaboration between the providers and the team.

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.

Summary: The content and style of the psychiatric clinics had improved since the last review. With sustained high performance, this indicator (35), might be moved to the category of less oversight after the next review. This is also the case for the regular completion of quarterly reviews. Some attention should be paid to ensuring that the review documentation includes the required components, some were missing from each review. These indicators will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
33	Quarterly reviews were completed quarterly.	100% 8/8	1/1	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1
34	Quarterly reviews contained required content.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3	N/A	1/1	1/1	N/A	1/1	N/A	N/A	N/A	N/A

Comments:
33. Quarterly evaluations were completed in a timely manner. Individual #156 was admitted to the facility in September 2016. Her initial CPE was done at that time. There was a quarterly evaluation completed 12/6/16. As there had only been one quarterly clinic since admission, it was not possible to determine a pattern of compliance for her.

34. The Monitoring Team looks for nine components of the quarterly review. In general, reviews were missing three to four components; most commonly, a review of the implementation of non-pharmacological interventions recommended by the psychiatrist and approved by the IDT, basic information (timely height, weight, and vital signs), and the attendance sign-in sheet.

35. Psychiatry clinic was observed for three individuals. The psychiatry clinic was organized and comprehensive. All attendees gave a presentation of their data and this was used to make decisions regarding medications and treatment.

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	161	179	60	156	111	112	159	37	153
36	A MOSES & DISCUS/MOSES was completed as required based upon the medication received.	22% 2/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	0/1	0/1
Comments: 36. Assessments were not routinely occurring in a timely manner. When the assessments were done, prescriber review was timely for almost all cases.											

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary: These indicators were moved to the category of requiring less oversight after the last review. This remained a strength of the facility's psychiatry department. The psychiatrist remained actively involved and available.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: These important indicators met criteria during this review, with but one exception. They will, however, remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments:
42. There was one individual, Individual #159, who was admitted in June 2016. The PBSP was not finalized until March 2017. Individual #156 was admitted in September 2016. Although the PBSP was not finalized until September 2017, there was documentation of an interim PBSP for Individual #156 that was utilized prior to the development of the final program.

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 designation, review, and committee were regularly functioning parts of the El Paso SSLC psychiatry program. Therefore, indicator 46 will be moved to the category of requiring less oversight. Some attention needs to be paid to ensure that all individuals have justification and plans/rationales. Thus, indicators 44 and 45 will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	80% 4/5	1/1	N/A	N/A	0/1	N/A	1/1	1/1	N/A	1/1
45	There is a tapering plan, or rationale for why not.	80% 4/5	1/1	N/A	N/A	1/1	N/A	1/1	0/1	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% 4/4	1/1	N/A	N/A	N/A	N/A	1/1	1/1	N/A	1/1

Comments:
44. These indicators applied to five individuals. Polypharmacy justification was appropriately documented for four individuals. Individual #156 was prescribed a new medication in January 2017. At that time, she met criteria for polypharmacy. There was no documentation provided regarding the initiation of this medication or the justification for the polypharmacy.

45. There was documentation of a rationale regarding medication tapers for four individuals (not for Individual #159).

46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for four individuals selected by the Monitoring Team meeting criteria for polypharmacy. One individual, Individual #156, met criteria for polypharmacy as of January 2017. She had not been added to the polypharmacy tracking list as of this monitoring visit. The polypharmacy committee meeting was observed during the visit and was a facility level review of regimens. This was good to see.

Psychology/behavioral health

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: One of the three individuals who had reliable data was making progress. The others were not making progress and/or there were not any reliable data to make that determination. Goals were not updated based upon progress or lack of progress. These four indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
6	The individual is making expected progress	14% 1/7	0/1	1/1	N/A	0/1	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.	0% 4/4	0/1	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1
9	Activity and/or revisions to treatment were implemented.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: 6. Individual #179's data were demonstrated to be reliable (see indicator #5) and he was making progress. Individual #161, Individual #112, Individual #156, and Individual #153 were not making progress. Individual #159 was progressing, however, he was scored as 0 because his data were not demonstrated to be reliable. Individual #111's progress could not be determined because her progress note had no PBSP data since September 2016 and her data were not demonstrated to be reliable, so she was not scored as progressing. 8. Individual #156, Individual #153, Individual #112, and Individual #161 were not making expected progress, however, their progress notes did not include actions to address the absence of progress. Intervening when progress is not occurring is a typical aspect of behavioral health services programming and should be occurring regularly at El Paso SSLC.											

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: El Paso SSLC had numerous behavior specialists, behavior coaches, and behavior analysts. Even so, there was no evidence that all staff were formally trained in PBSPs or that summaries were available for float staff (and all staff, too). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
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% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1

17	There was a PBSP summary for float staff.	0% 0/7	0/1	0/1	N/A	0/1	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.	71% 5/7	1/1	0/1	N/A	1/1	1/1	0/1	1/1	N/A	1/1

Comments:
16-17. 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 its implementation. Additionally, none of the individuals had evidence of an abbreviated PBSP for float staff to review. Ensuring that all DSPs are trained on the implementation of PBSPs, and having current and easy-to-follow PBSP summaries available for staff are critical first steps for ensuring that staff are implementing PBSPs as written.

18. Individual #179 and Individual #112's functional assessments and/or PBSPs were not written by a behavioral specialist who was enrolled in, or had completed, BCBA coursework.

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

Summary: Data presentation was occurring during clinical meetings and peer review (indicators 21 and 22) and progress notes (indicator 19) commented on the individual's status (with one exception for one individual who did not have notes completed for many months). With sustained high performance, these three indicators might be moved to the category of requiring less oversight after the next review. Graphing and internal peer review requirements (indicators 29 and 23) will need some attention in order for progress to occur. All five indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
19	The individual's progress note comments on the progress of the individual.	86% 6/7	1/1	1/1	N/A	1/1	0/1	1/1	1/1	N/A	1/1
20	The graphs are useful for making data based treatment decisions.	0% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	0/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 3/3	N/A	1/1	1/1	N/A	1/1	N/A	N/A	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 recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external	0%									

	peer review occurred at least five times, for a total of at least five different individuals, in the past six months.		

Comments:

19. Individual #111 did not have a progress notes since September 2016, therefore, this indicator was scored as 0 for her.

20. Individual #156 and Individual #153 did not have graphs in their progress notes. The last graph in Individual #111, Individual #112, Individual #159, and Individual #161's progress notes was September 2016. The last graph in Individual #179's progress note was October 2016. The behavioral health services staff indicated that they did have updated graphs (the Monitoring Team noted updated graphs in IDT meetings- see indicator 21), however, in order to be most useful, current graphs should be in each individual's progress note. Therefore, this indicator was scored zero for all individuals.

21. In order to score this indicator, the Monitoring Team observed Individual #111, Individual #60, and Individual #179's psychiatric clinic meetings. In all three meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. Individual #56's peer review minutes were used to score this indicator. The minutes from his February 2017 peer review suggested plans which would contribute to reductions in his behavioral targets. There was evidence of follow-up/implementation of those recommendations.

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

Outcome 8 – Data are collected correctly and reliably.

Summary: El Paso SSLC's data collection systems adequately measured target and replacement behaviors and the facility set treatment and data integrity measures and goals. The goals were met for three individuals. Given the recent changes in the electronic health record as well as the scores for indicator 30, this outcome and its indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 161	179	60	156	111	112	159	37	153
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	100% 7/7	1/1	1/1	N/A	1/1	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% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1
29	If the individual has a PBSP, there are established goal frequencies	100%	1/1	1/1	N/A	1/1	1/1	1/1	1/1	N/A	1/1

	(how often it is measured) and levels (how high it should be).	7/7									
30	If the individual has a PBSP, goal frequencies and levels are achieved.	43% 3/7	1/1	1/1	N/A	0/1	0/1	1/1	0/1	N/A	0/1

Comments:
26-28. There were adequate data collection systems in place.

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

30. Goal frequencies and levels of data collection timeliness, IOA, and treatment integrity were achieved for Individual #179, Individual #112, and Individual #161. Individual #159, Individual #153, and Individual #156 did not have IOA, DCT, or treatment integrity assessments conducted in the last six months. Individual #111 had IOA, DCT, and treatment integrity scores collected on 10/16/16, with IOA and treatment integrity at 100%. Her DCT, however, was 0%. When IOA, treatment integrity, or data collection timeliness are below the minimal level, staff should be immediately retrained and the assessment re-administered. Improving the reliability of PBSP data, and the integrity of the implantation of the PBSPs should be a priority for El Paso SSLC.

Medical

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

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

			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	Individual has a measurable and time-bound goal(s)/objective(s) to measure the efficacy of interventions.	0% 0/18	0/2	0/2	0/2	0/2	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).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal(s)/objective(s).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #37 – other: thrombocytopenia, and other: Vitamin D deficiency; Individual #111 – osteoporosis, and cardiac disease; Individual #15 –

cardiac disease, and other: renal disease; Individual #188 – diabetes, and cardiac disease; Individual #32 – diabetes, and infections; Individual #89 – diabetes, and osteoporosis; Individual #46 – other: hypertension, and diabetes; Individual #162 – GI problems, and other: hypothyroidism; and Individual #10 – diabetes, and osteoporosis).

c. through e. 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: Four of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, the Monitoring Team will continue to review these indicators 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 Center 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	37	111	15	188	32	89	46	162	10
a.	Individual receives timely preventative care:										
	i. Immunizations	78% 7/9	1/1	1/1	0/1	1/1	1/1	1/1	0/1	1/1	1/1
	ii. Colorectal cancer screening	86% 6/7	N/A	1/1	0/1	N/A	1/1	1/1	1/1	1/1	1/1
	iii. Breast cancer screening	100% 2/2	N/A	1/1	N/A	N/A	N/A	N/A	1/1	N/A	N/A
	iv. Vision screen	67% 6/9	1/1	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1
	v. Hearing screen	100% 8/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	78% 7/9	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	vii. Cervical cancer screening	100%	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A

		2/2									
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:

- Individual #37's 12/13/11 bone mineral density test should have been repeated in five years, but was not.
- For Individual #15:
  - His varicella status was unclear. Documentation indicated that a varicella immune globulin was given in 2014. However, there was no documentation that the individual received the vaccination. In addition, there was no documentation of the administration of the Prevnar 13 vaccine.
  - Response to the document request indicated that a colonoscopy was pending, but the Preventative Care Flow Sheet noted that it was done in 2011.
  - Individual #15 had an eye appointment on 2/11/15 that noted bilateral cataracts, but no follow-up was found.
  - Of note, the AMA stated that in 2013, Individual #15 did not cooperate for a mammogram, and in 2015, a breast ultrasound was negative. However, there was no explanation in the AMA why this was done for this 62-year-old man.
  - In November 2015, a DEXA scan showed osteoporosis, and in October 2016, Individual #15 had an atypical hip fracture. The orthopedist noted in the consult that this atypical fracture could potentially be related to the use of denosumab. Of note, the internal medicine consultant decided to continue its use even though the specialist suggested discontinuing it. There was no referral to endocrinology for additional evaluation of an individual with osteoporosis who sustained an atypical hip fracture while being treated with denosumab. The association of an atypical hip fracture and the use of denosumab is potentially an FDA reportable event.
- For Individual #188, a 10/19/11 bone mineral density test should have been repeated in five years, but was not. In addition, she was prescribed quetiapine, and should have had an eye evaluation done in June 2015. An attempt to complete an annual exam was not made until December 2016, and the appointment had to be rescheduled.
- Individual #32's last vision screening was in 2015, but he needs an annual screening due to quetiapine use.
- For Individual #46, documentation of the Prevnar 13 vaccination was not found.

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 Score	37	111	15	188	32	89	46	162	10

a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A										
	Comments: Based on the documentation provided, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed had DNRs in place.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Overall, the quality of medical practitioners' assessment and follow-up on acute issues treated at the Center and/or in other settings varied, and for some individuals reviewed, significant concerns were noted. In fact, in comparison with the previous review, for most indicators, the Center's performance decreased. The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	25% 3/12	1/2	0/1	0/1	1/2	0/2	1/1	0/1	0/1	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.	25% 3/12	1/2	0/1	0/1	1/2	0/2	0/1	0/1	1/1	0/1
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, or if unable to assess prior to transfer, within one business day, the PCP or a provider provides an IPN with a summary of events leading up to the acute event and the disposition.	13% 1/8	0/1	N/A	0/1	N/A	0/1	N/A	1/2	0/1	0/2
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	25% 1/4	N/A		N/A		0/1		1/1	0/1	0/1
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	43% 3/7	N/A		0/1		1/1		1/2	0/1	1/2
f.	If individual is transferred to the hospital, PCP or nurse	Due to the Center's sustained performance with this indicator, it has									

	communicates necessary clinical information with hospital staff.	moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as appropriate.	29% 2/7	0/1		0/1		0/1		1/1	0/1	1/2
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	0% 0/8	0/1		0/1		0/1		0/2	0/1	0/2

Comments: a. and b. For the nine individuals reviewed in relation to medical care, the Monitoring Team reviewed 12 acute illnesses addressed at the Center, including the following with dates of occurrence: Individual #37 (paronychia on 10/30/16, and upper respiratory infection on 11/25/16), Individual #111 (dermatitis and hypernatremia on 12/7/16), Individual #15 (folliculitis on 12/17/16), Individual #188 (nasopharyngitis on 12/29/16, and bloody stools on 12/21/16), Individual #32 (fall and hematoma on 2/11/17, and constipation on 1/12/17), Individual #89 (upper respiratory infection on 10/4/16), Individual #46 (GI bleed on 9/21/16), Individual #162 (nasopharyngitis on 12/16/16), and Individual #10 (lethargy and hypophosphatemia on 2/3/17) .

The acute illnesses for which documentation was present to show that medical providers assessed the individuals according to accepted clinical practice were for Individual #37 (paronychia on 10/30/16), Individual #188 (nasopharyngitis on 12/29/16), and Individual #89 (upper respiratory infection on 10/4/16).

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 were those for Individual #37 (upper respiratory infection on 11/25/16), Individual #188 (nasopharyngitis on 12/29/16), and Individual #162 (nasopharyngitis on 12/16/16).

The following provide examples of concerns noted:

- On 12/7/16, Individual #111 was seen for diaper dermatitis. The provider ordered local wound care. Individual #111 was also noted to have dehydration. This was based on a sodium level of 147. The provider did not record vital signs, such as heart rate and blood pressure. The plan was to increase fluids and recheck labs on 12/9/16. There was no follow-up. On 12/22/16, a sodium of 150 was documented. The plan was to increase water and repeat labs. Again, there was no follow-up documented for the hypernatremia. The next PCP note was dated 2/22/17, and this was related to ear pain and fever.
- On 12/17/16, nursing staff sent a message requesting that Individual #15 be seen for a skin infection. On 12/19/16, the PCP saw the individual for folliculitis. No treatment was prescribed. Follow-up was scheduled for two weeks, but there was no follow-up documented.
- On 12/21/16, Individual #188 presented to the clinic for evaluation of bloody stool that was documented on 12/17/16. From 12/2/16 to 12/3/16, her menses occurred, and again on 12/19/16. The individual did not cooperate for a rectal exam. Labs were obtained, and nursing staff were to monitor with follow-up scheduled in one week. However, there was no discussion of this problem in the IPN dated 12/29/16. On 1/12/17, the PCP noted that the bloody stool occurred during her menses, but this was not consistent with the original note. The PCP determined that follow-up was not required.

- On 2/11/17, Individual #32 fell and developed a hematoma to the right ear. There was no PCP evaluation until 2/14/17. The physical exam was incomplete for an individual with a history of head trauma and a recent history of a subarachnoid hemorrhage secondary to a head injury that occurred in October 2016, when the individual fell and hit his head.
- On 1/12/17, the PCP evaluated Individual #32 noting that there had been no bowel movement in five days. It was also documented that: "staff requesting f/u CXR [chest x-ray]." The assessment was constipation due to anticholinergic burden and lack of exercise. The plan was to check labs, increase fluids, add a bulk forming laxative, and repeat the chest x-ray. The x-ray done on 1/12/17 showed a right lung infiltrate. There was no follow-up documented for any of these problems. Additionally, the Center should have guidelines for management of pneumonia that include the protocol for obtaining follow-up chest x-rays.
- On 9/21/16, nursing staff documented that Individual #46 had 100 cubic centimeters (cc) of dark brown fluid in her gastrostomy tube (G-tube). It was also noted that the individual had a distended abdomen and groaned with abdominal palpation. The PCP was notified and requested that enteral nutrition be held. On 9/21/16, the PCP documented an assessment noting a history of dark brown stomach contents and moaning. The physical exam was significant for a distended but non-tender abdomen. The plan was to have a GI evaluation and check a KUB (abdominal x-ray) and gastric guaiac. On 9/23/16, a consult note regarding the GI consult/esophagogastroduodenoscopy (EGD) was written, but the PCP documented no follow-up assessment. The next PCP documentation was on 10/3/16, and this was for evaluation of a two-minute seizure.
- On 2/3/17, at approximately 1:00 p.m., nursing staff noted via email that Individual #10 was lethargic and a medical provider needed to see him. At 2:48 p.m., the PCP documented: "discussed case with clinic nurse, vital signs stable, POX [pulse oximetry] stable. Monitor." At approximately 4:50 p.m., the individual was transferred to the ED for a critically low phosphorus level. It was unclear why the PCP did not conduct an evaluation, given that nursing provided a history of new lethargy and change in status.

c. through h. For six of the nine individuals reviewed, the Monitoring Team reviewed eight acute illnesses requiring hospital admission, or ED visit, including the following with dates of occurrence: Individual #37 (hospitalization for suicidal ideation on 12/2/16), Individual #15 (aspiration pneumonitis on 12/14/16), Individual #32 (subarachnoid hemorrhage on 10/5/16), Individual #46 (hypoxia on 11/4/16, and aspiration pneumonia on 11/16/16), Individual #162 (tube replacement on 12/9/16), and Individual #10 (hypophosphatemia and aspiration pneumonia on 1/11/17, and hypophosphatemia on 1/21/17).

Of note, the Center did not provide any hospital records. The only information submitted for document request #15 (i.e., For any individual with ED visits or Hospitalization, hospitalization records, including, for example, records that the hospital provided to the Facility, and related IPNs for last six months, including as applicable Hospitalization/ER/LTAC related records, labs, x-rays, Neuro checks, Hospital Liaison Reports, Transfer Record, Hospital Discharge Summary, ED notes, admit history and physical, consults, etc.) was the Hospital Liaison notes. Therefore, the hospital diagnosis available was limited to notes from the Hospital Liaison. The status of the individual upon arrival to the hospital, the condition at discharge, and the official hospital diagnosis could not be verified without the hospital admission history and physical, and discharge summary.

c. and d. For Individual #46 (hypoxia on 11/4/16), a PCP IPN was completed showing a quality assessment prior to transfer.

e. The individuals reviewed that received timely treatment at the SSLC were Individual #32 (subarachnoid hemorrhage on 10/5/16), Individual #46 (aspiration pneumonia on 11/16/16), and Individual #10 (hypophosphatemia on 1/21/17).

g. It was of significant concern that when IDTs met to discuss individuals' hospitalizations, PCPs often were not present.

h. It also was concerning that PCPs had not 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.

The following provide examples of concerns noted:

- On 12/2/16, Individual #37 was transferred to the hospital for suicidal ideations (he was at work at the time this occurred). On 12/6/16, he was transferred to the psychiatric hospital, and on 12/7/16, he returned to the Center. The first PCP assessment was not completed until 12/13/16.
- On 12/14/16, nursing staff documented that Individual #15 had an oxygen saturation rate of 85% on room air that increased to 94% with supplemental oxygen. The PCP was notified and requested that the individual be seen in clinic in the morning. A second note documented that the PCP was called at 2:46 a.m., and was informed that the individual did not look like he was doing well. Orders were given to transfer him to the hospital. The nursing IPN documentation included the date and time that the note was written, but did not provide a time that the actual assessments occurred. On 12/16/16, the individual returned to the Center, and the PCP saw him and noted that the discharge diagnosis was aspiration pneumonia. On 12/17/16, nursing staff sent a message requesting that the individual be seen for a skin infection. On 12/19/17, the PCP saw the individual for folliculitis. Follow-up was scheduled for two weeks. On 12/21/16, the PCP documented that the aspiration pneumonitis was resolved. This individual did not have the required post-hospital assessments. The PCP should have conducted follow-up for a minimum of two consecutive days and more, if warranted. In addition, although the IDT held a post-hospital ISPA meeting, the PCP was not in attendance.
- According to nursing documentation, on 10/5/16, Individual #32 fell. A two- to three-centimeter head laceration and blood in the individual's mouth were reported. Per nursing staff, the PCP was contacted and requested to "hold him there and monitor." The PCP "was going to lunch" and would see the individual upon return. After being unable to reach the PCP for notification of "possible hematoma increasing to left temporal area," the nurse called 911. Emergency Medical Services (EMS) transferred the individual to the hospital, where he was diagnosed with a subarachnoid hemorrhage. Based on the PCP's documentation, he was intubated for a follow-up CT scan, and subsequently aspirated and developed pneumonia. His status deteriorated and he required a tracheostomy and gastric tube insertion. On 11/9/16, he was transferred to a long-term acute care (LTAC) facility, and on 12/1/16, returned to the Center. PCP follow-up was not documented until 12/5/16, and was related to poor oral hygiene, and Individual #32's refusal to accept oral care. On 12/2/16, the IDT held an ISPA meeting, but the PCP was not in attendance.
- According to PCP documentation, on 11/4/16, Individual #46 was sent to the ED via EMS after a code blue was called. The individual had transient hypoxia "that appeared to be due to aspiration." The PCP noted that the individual was clinically stable after returning from the ED. There was no additional follow-up related to this incident. The next PCP documentation was an IPN entry related to a skin integrity meeting on 11/10/16.

  On 11/13/16, nursing staff documented that Individual #46 had a temperature of 101.4. The nursing fever protocol was implemented and the individual was given acetaminophen. There was no documentation of physician notification or assessment. On 11/16/16, nursing staff noted that the individual was in respiratory distress and a code blue was called. At

7:00 a.m., the individual was transferred to the hospital and admitted with aspiration pneumonia. On 11/21/16, Individual #46 returned to the Center, and on 11/22/16, the PCP saw her. The PCP noted the discharge diagnosis was chronic megacolon due to pseudo obstruction and chronic constipation. On 11/23/16, the individual was transferred to the hospital again and readmitted with megacolon, and returned on 11/29/16. The PCP post-hospital follow-up for this admission was documented on 12/2/16. However, on 11/30/16, the individual was transferred to the hospital again and admitted with the diagnoses of hypokalemia and seizure disorder. On 12/5/16, she returned to the Center and the PCP saw her. On 12/7/16, the PCP documented a note indicating the individual had apnea and was being transported to the hospital. On 12/30/16, Individual #46 died with causes of death listed as respiratory failure, megacolon, quadriparesis, and mental retardation.

- On 1/11/17, nursing documented that Individual #10 was being transferred to the hospital due to high phosphorus levels. On 1/16/17, the individual returned to the Center. On 1/17/17, the PCP conducted a post-hospital assessment noting that the admit diagnoses were hypophosphatemia, aspiration pneumonia, and systemic inflammatory response (SIRS). Follow-up occurred on 1/20/17, but there should have been follow-up for a minimum of two consecutive days. The PCP noted the RN Case Manager was concerned about hypoglycemia and hypoxia during the night time. The plan was to decrease the evening dose of Neutral Protamine Hagedorn (NPH) insulin, and obtain a pulmonary consult to determine if a sleep study was warranted.

  According to nursing documentation, on 1/21/17, the individual was transferred to the hospital due to hypophosphatemia. On 1/23/17, the individual returned, and on 1/24/17, the PCP saw him. The diagnosis was hypophosphatemia and hypomagnesemia. The possibility of a malabsorption syndrome was raised, yet there was no specific plan to address this concern. There was no additional follow-up.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: The Center should focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. Given that the PCP IPNs for consultations that should have been referred to the IDTs often did not comment on whether or not IDT review was needed, if this issue is not corrected, then Indicator c will be brought back into active monitoring after the next review.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	If individual has non-Facility consultations that impact medical care, PCP indicates agreement or disagreement with recommendations, providing rationale and plan, if disagreement.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.										
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.										
d.	If PCP agrees with consultation recommendation(s), there is evidence it was ordered.										
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	0% 0/4	N/A	0/1	N/A	N/A	N/A	0/1	N/A	N/A	0/2

Comments: For seven of the nine individuals reviewed, the Monitoring Team reviewed a total of 14 consultations. The consultations reviewed included those for Individual #37 for dermatology on 11/2/16, and dermatology on 1/9/17; Individual #111 for eye on 12/16/16, and gastroenterology (GI) on 10/3/16; Individual #15 for GI on 1/27/17, and orthopedics on 11/29/16; Individual #89 for nephrology on 11/4/16, and audiology on 12/7/16; Individual #46 for GI on 10/10/16, and GI on 9/8/16; Individual #162 for GI on 11/30/16, and dermatology on 11/28/16; and Individual #10 for health department on 12/6/16, and pulmonary on 11/16/16.

c. Although this indicator moved to less oversight after the last review, the Monitoring Team still needed to assess Indicator e, and therefore, reviewed the PCP IPNs to determine whether or not referral to the IDT was warranted. Unfortunately, it appeared that PCPs were not consistently commenting on whether or not referral to the IDT was needed. If Center staff do not correct this issue, then this indicator will be brought back into active monitoring.

e. Given that possible cataract surgery was raised in Individual #111's ophthalmology consultation on 12/16/16, a referral should have been made to the IDT, but was not.

Individual #89 was seen for evaluation of hypernatremia. The recommendation was to increase free water. Given the need to see that this was implemented, the IDT should have been made aware of the recommendation, and discussed modifications to his current IHCP(s).

For the 11/16/16 consultation for Individual #10 to pulmonology, the PCP did not provide any information to the specialist. The PCP should provide clinical information and diagnostic data, as appropriate. The pulmonologist was not provided any information regarding the history of LTBI and/or the recent hemoptysis that occurred in September 2016. The pulmonologist had no new recommendations causing the PCP to document: "Disappointment – can't offer anything new or different?'' This consultation report should have been referred to IDT for review and consideration of a second opinion if the IDT was not satisfied with the outcome.

Individual #10 had a consultation with the El Paso County Health Department for re-evaluation of latent tuberculosis infection (LTBI) due to recent episodes of hemoptysis. According to the 12/6/16 case review: "Patient not physically seen/evaluated. He had been evaluated earlier in the late summer." The recommendation was not to treat for LTBI due to the high risk of hepatotoxicity. The PCP agreed with the recommendation. The IPN did not include documentation of the need to refer the consultation report to the IDT. However, the IDT should have been made aware of this decision, and staff should have received training on the surveillance needed for an individual with LTBI.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.											
Summary: The Center should focus on ensuring that for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCP identifies the necessary treatment(s), interventions, and strategies, as appropriate. This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	39% 7/18	1/2	1/2	0/2	1/2	0/2	1/2	1/2	1/2	1/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #37 – other: thrombocytopenia, and other: Vitamin D deficiency; Individual #111 – osteoporosis, and cardiac disease; Individual #15 – cardiac disease, and other: renal disease; Individual #188 – diabetes, and cardiac disease; Individual #32 – diabetes, and infections; Individual #89 – diabetes, and osteoporosis; Individual #46 – other: hypertension, and diabetes; Individual #162 – GI problems, and other: hypothyroidism; and Individual #10 – diabetes, and osteoporosis).

a. It was positive that the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #37 – other: Vitamin D deficiency, Individual #111 – cardiac disease, Individual #188 – cardiac disease, Individual #89 – osteoporosis, Individual #46 – other: hypertension, Individual #162 – other: hypothyroidism, and Individual #10 – osteoporosis. The following summarizes examples of concerns noted:

- Individual #37 has persistent thrombocytopenia, which was worsening with the last platelet count of 114 thousand on 2/6/17. This is considered mild thrombocytopenia. However, it should be noted that the platelet count was decreasing and there was no evidence that the appropriate workup had been done. In an individual with incidentally discovered asymptomatic thrombocytopenia, there should be documentation of a thorough history, physical examination, complete blood count (CBC), and review of the peripheral blood smear. Testing for human immunodeficiency virus (HIV) and Hepatitis C is also considered part of the basic workup. Individual #37's AMA provided no documentation of the routine workup, information on the potential etiology of the thrombocytopenia, or a hematology consult. It simply noted the platelet count was stable and follow-up should occur with internal medicine. The Center must ensure that individuals receive appropriate specialty consultation, when needed. The Internal Medicine consult, dated 9/9/16, provided no information on the suspected etiology of the thrombocytopenia. The consult, dated 3/7/17, noted that the individual was asymptomatic, but also noted that the platelet count had decreased to 114 thousand. It would be important to establish a cause and minimize further decrease in the platelet count, if possible.
- Individual #15's May 2016 AMA provided no information related to the stage of his chronic kidney disease or the etiology. The assessment was renal insufficiency and the plan was: "Follow-up with Nephrology as scheduled." The assessment and plan should provide information on the status of the condition as well as how it is to be managed. Follow-up with nephrology only was not an appropriate plan. No hospital records were provided, but the Quarterly Medical Summary, dated 1/6/17, noted that

the individual developed acute kidney injury during an October hospitalization. The AMA also documented microalbuminuria as a problem without defining the significance of the problem. The plan was: "Continue Lisinopril," which was not sufficient.

- Individual #188's AMA did not discuss the risk of diabetes and metabolic syndrome for this individual who was obese, and was treated with a second-generation antipsychotic. The last Hemoglobin (Hb) A1c was done on 12/18/15, and was 5.5, which is at the upper limits of normal. The plan was to continue increased physical activity and a low cholesterol diet. There was no repeat HbA1c.
- Similarly, for Individual #32, who had prediabetes (which the Center staff incorrectly referred to as borderline diabetes), there was no discussion of diabetes prevention as outlined by the American Diabetes Association (ADA).
- Individual #32 had chronic Hepatitis B Infection. According to the AMA, GI followed the individual, and the recommendation was to have an ultrasound of the abdomen and alpha-fetoprotein (AFP) level every six months; check the DNA hepatitis B virus (HBV) yearly, and alanine transaminase (ALT) every three months. The AMA stated that the individual refused to have a CT of the abdomen. GI did not appear to recommend a CT scan of the abdomen. Overall, there was no documentation that the surveillance for chronic Hepatitis B was implemented as the gastroenterologist recommended. The date of the last GI consult was not documented. No discussion of this chronic illness was found in the individual's IRRF and/or IHCP.
- For Individual #46, the AMA did not assess her risk for metabolic syndrome.
- According to Individual #162's IRRF, the PCP commented that the gastroenterologist "may feel that the facility is not being careful and his tube is coming out too often." This occurred six times in six months. The AMA did not discuss the diagnosis of severe dysphagia, but noted that the tube had been dislodged multiple times. The section on gastroesophageal reflux disease (GERD) simply stated to follow the PNMP, but provided no information on the supports needed.
- Individual #10 had poorly controlled diabetes mellitus with frequent episodes of significant hypoglycemia over a period of many months. On 10/27/16, the individual was referred to the Center's Internal Medicine consultant who recommended referral to Endocrinology. The complexity of this individual's diabetic management was a clear indication of the need for referral to Endocrinology. This consult did not occur until February 2017. It should be noted that the ADA guidelines clearly state that A1c goals are not set until hypoglycemia is controlled. The Center should ensure that referrals are made to the appropriate consultants in a timely manner.

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. Moreover, documentation often was not found to show implementation of those action steps assigned to the PCPs that IDTs did include in IHCPs/ISPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.

Individuals:

#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	39% 7/18	1/2	1/2	1/2	1/2	0/2	1/2	0/2	1/2	1/2

	Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, those action steps assigned to the PCPs that were identified for the individuals reviewed frequently were not implemented. The ones that were implemented were included in the IHCPs for Individual #37 – other: Vitamin D deficiency, Individual #111 – cardiac disease, Individual #15 – cardiac disease, Individual #188 – cardiac disease, Individual #89 – osteoporosis, Individual #162 – other: hypothyroidism, and Individual #10 – osteoporosis.

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	37	111	15	188	32	89	46	162	10
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	N/R									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									

Comments: 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: Due to previous high performance with regard to the completion of quality QDRRs, Indicator b was moved to the category requiring less oversight, along with indicators a and c. However, based on use of the QDRRs for other elements of the Monitoring Team's review, problems were noted with regard to the Pharmacist noting all relevant lab values, and addressing irregularities through recommendation to prescribers. As a result, Indicator b will move back to active monitoring. It was good to see improvement with regard to implementation of the agreed-upon recommendations.

Individuals:

#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the										

	QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:	However, due to poor performance, Indicator b will move back to active monitoring.									
	i. Laboratory results, including sub-therapeutic medication values;										
	ii. Benzodiazepine use;										
	iii. Medication polypharmacy;										
	iv. New generation antipsychotic use; and										
	v. Anticholinergic burden.										
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.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	91% 10/11	N/A	2/2	1/1	2/2	1/1	1/2	N/A	2/2	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: b. Due to previous high performance with regard to the completion of quality QDRRs, Indicator b was moved to the category requiring less oversight, along with indicators a and c. However, based on use of the QDRRs for other elements of the Monitoring Team's review, problems were noted with regard to the Pharmacist noting all relevant lab values, and addressing irregularities through recommendation to prescribers. QDRRs that did not sufficiently address laboratory results included those for Individual #37, Individual #111, Individual #15, Individual #46, and Individual #10. In many cases, the Clinical Pharmacist noted lab values of concern, but did not comment on whether such lab values were potentially related to medications, and/or follow-up with a recommendation.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was generally present to show they implemented them. The exception was for Individual #89's QDRR, dated 10/21/16, which recommended that the prescriber add a diagnosis, and order labs. The prescriber did not indicate agreement or disagreement, and the same recommendations were made in the next QDRR, dated 1/27/17. The recommendations were then implemented.

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	37	111	15	188	32	89	46	162	10
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/7	0/1	0/1	0/1	0/1	0/1	N/A	0/1	0/1	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	14% 1/7	1/1	0/1	0/1	0/1	0/1		0/1	0/1	
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1	0/1	
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1	0/1	
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/7	0/1	0/1	0/1	0/1	0/1		0/1	0/1	

Comments: a. and b. Individual #89 and Individual #10 were edentulous and were at low risk for dental, so limited reviews were conducted. The Monitoring Team reviewed eight individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

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 #37's goal/objective related to receiving two prophylactic care visits.

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. For eight individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: The Monitoring Team will continue to review these indicators.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10

a.	Individuals have no diagnosed or untreated dental caries.	0% 0/6	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1	N/A
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.	0% 0/1	0/1	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.	0% 0/5	N/A	0/1	0/1	0/1	0/1	N/A	N/A	0/1	N/A
c.	Since the last exam, the individual's fair or good oral hygiene score was maintained or improved.	N/R									

Comments: Of concern, the Registered Dental Hygienists often documented dental notes with no documentation from a dentist. There was little documentation by the dentist regarding dental findings, treatment, treatment plans, and radiograph results. The dentist should provide documentation of dental treatment, diagnostics, and findings.

a. and b. Individual #89, Individual #46, and Individual #10 were edentulous. For many of the individuals reviewed, because up-to-date dental exams were not submitted, evidence was not available to confirm that they had no untreated dental caries, and/or determine the status of their periodontal condition.

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

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: It was of significant concern that the Center had not provided needed dental care to a number of individuals reviewed, including prophylactic care, x-rays, fluoride application, treatment for periodontal disease, and/or restorative work. The Center needs to focus on the provision and quality of dental treatment.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
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.	17% 1/6	1/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1	N/A
b.	At each preventive visit, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	Due to the Center's sustained performance with this indicator, it has moved to the category requiring less oversight.									
c.	Individual has had x-rays in accordance with the American Dental	50%	1/1	0/1	0/1	1/1	0/1			1/1	

	Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	3/6									
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	0% 0/4	N/A	N/A	0/1	0/1	0/1			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.	17% 1/6	1/1	0/1	0/1	0/1	0/1			0/1	
f.	If the individual has need for restorative work, it is completed in a timely manner.	0% 0/2	0/1	N/A	N/A	N/A	0/1			N/A	
g.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									
Comments: a. through f. Individual #89, Individual #46, and Individual #10 were edentulous. Of significant concern, a number of individuals reviewed had not had needed dental treatment.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									
b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a. through c. Based on documentation submitted, none of the individuals reviewed had dental emergencies in the six months prior to the review.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.	
Summary: Given the Center's sustained performance during this review and the last three reviews (i.e., Round 9 – 100%, Round 10 – 100%, Round 11 – 100%, and Round 12 – 100%), Indicator b related to providing individuals with suction tooth brushing according to the schedule in their ISPs will move to the category requiring less oversight. The Center needs to develop and/or implement a system for monitoring staff's implementation of suction tooth brushing for quality, as well as safety, and focus on QIDP monthly reviews including specific data and analysis of	Individuals:

data related to suction tooth brushing, as appropriate.											
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	80% 4/5	N/A	N/A	1/1	N/A	1/1	N/A	0/1	1/1	1/1
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	100% 4/4			1/1		1/1		N/A	1/1	1/1
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4			0/1		0/1		N/A	0/1	0/1
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4			0/1		0/1		N/A	0/1	0/1
Comments: a. Individual #46 was assessed as not needing suction tooth brushing. However, she presented often at the dental clinic with poor oral hygiene with thick build-up noted on her tongue and palate. She received nothing by mouth, so daily suction tooth brushing might be helpful to address the build-up. It was unclear why it was not considered. c. Dental Department staff need to develop and/or implement a system for monitoring staff's implementation of suction tooth brushing for quality, as well as safety.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Some improvements were noted with regard to the dentist's assessment of the need for dentures for individuals with missing teeth.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	71% 5/7	N/A	1/1	1/1	N/A	1/1	0/1	0/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: None.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Nursing assessments at the onset of signs and symptoms of illness, as well as on an ongoing basis for acute illnesses/occurrences remained areas on which the Center needs to focus. It is also important that nursing staff timely notify the practitioner/physician of such signs and symptoms in accordance with the nursing guidelines for notification. Nursing staff were not developing acute care plans for all relevant acute care needs, and those that were developed needed significant improvement. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	10% 1/10	1/1	0/1	0/2	N/A	0/1	N/A	0/1	0/2	0/2
b.	For an individual with an acute illness/occurrence, licensed nursing staff timely and consistently inform the practitioner/physician of signs/symptoms that require medical interventions.	10% 1/10	0/1	0/1	0/2		1/1		0/1	0/2	0/2
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0% 0/6	0/2	0/1	N/A		N/A		N/A	0/2	0/1
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	0% 0/5	N/A	N/A	0/2		0/1		0/1	N/A	0/1
e.	The individual has an acute care plan that meets his/her needs.	0% 0/11	0/2	0/1	0/2		0/1		0/1	0/2	0/2
f.	The individual's acute care plan is implemented.	0% 0/11	0/2	0/1	0/2		0/1		0/1	0/2	0/2
Comments: The Monitoring Team reviewed 11 acute illnesses and/or acute occurrences for seven individuals, including Individual #37 – swollen hand/ring finger on 10/30/16, and hospitalization for suicidal ideation on 12/2/16; Individual #111 - Clostridium Difficile (C-Diff) infection on 9/15/16; Individual #15 - spiral fracture of the distal left femur on 10/1/16, and aspiration pneumonia on 12/14/16; Individual #32 – fall with subarachnoid hemorrhage and hematoma on 10/5/16; Individual #46 – aspiration pneumonia on 11/16/16; Individual #162 - Acute nasopharyngitis and erythema around feeding tube on 12/16/16, and contact dermatitis to stoma site on 1/10/17; and Individual #10 - sepsis, hypophosphatemia on 1/12/17, and bronchitis on 2/14/17.											

a. Individual #37 was taken to the hospital from his community work site. The acute illness/occurrence for which nursing staff performed assessments (physical assessments) was for Individual #37 – swollen hand/ring finger on 10/30/16.

b. The acute illness/occurrence for which licensed nursing staff timely informed the practitioner/physician of signs/symptoms in accordance with the DADS SSLC nursing protocol entitled: "When contacting the PCP" was for Individual #32 – fall with subarachnoid hemorrhage and hematoma on 10/5/16.

e. For a number of acute issues, the Center did not submit acute care plans (e.g., Individual #37 – hospitalization for suicidal ideation on 12/2/16; Individual #15 - spiral fracture of the distal left femur on 10/1/16, and aspiration pneumonia on 12/14/16; Individual #32 – fall with subarachnoid hemorrhage and hematoma on 10/5/16; and Individual #46 – aspiration pneumonia on 11/16/16). Common problems with the acute care plans that were submitted included a lack of: instructions regarding follow-up nursing assessments that were consistent with the individuals' needs; 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:

- On 9/4/16, a note indicated a Licensed Vocational Nurse (LVN) reported that Individual #111 had three large #7 bowel movements (i.e., Bristol Chart classifies Type 7 as watery with no solid pieces). On 9/5/16, the next nursing IPN entries reported BMs, but there was no consistent nursing assessment of the individual's gastrointestinal system, including comparison of the stool to allow determination of whether or not it was improving or getting worse, or had an odor. It did not appear nursing staff reported the concerns to the PCP. On 9/13/16, a nursing IPN reported that a stool specimen was collected for testing for C-Diff, but no information was provided to explain what led up to the suspicion that Individual #111 had C. Diff. On 9/15/16, a skilled therapy IPN noted: "DSP report [Individual #111] continues to have loose stools. [DSP] reports she had 6 bowel movements during her 8 hour shift." The IPN also indicated the individual was " extremely fatigued." No corresponding IPN was found to show that nursing staff assessed Individual #111. Even after the prescription of broad spectrum antibiotics, ongoing nursing assessments were not found. Although an acute care plan was submitted, it was not individualized, and did not include necessary preventive measures (e.g., standard precautions). In addition, interventions did not include the frequency for interventions.
- Limited IView documentation was provided for Individual #15, and IPNs were also not complete. As a result, the Monitoring Team could not confirm that nursing assessments occurred. Of concern, it appeared Individual #15 returned from the LTAC without medical transfer orders or follow-up regarding his positioning, or what level of activity he could tolerate. The Hospital Liaison, Discharge Planning staff from the LTAC, and other team members should have been able to accomplish this task. Moreover, an acute care plan was not found to address his needs.
- On 10/5/16, Individual #32 fell and had a laceration to his head. An IPN documented nursing staff notified Individual #32's physician: "Called [PCP] and she stated she was going to lunch to hold him there and monitor and she would see him back when she returned from lunch." The IPN further stated the individual became more restless than usual, and the nurse noted that swelling to the temporal area was increasing. The nurse called 911, since she was unable to reach the PCP. It was very positive that the nurses acted promptly when Individual #32's signs and symptoms changed. However, because the Center did not

provide related IView documentation, the Monitoring Team could not confirm that nursing staff conducted necessary assessments. Based on the PCP's documentation, Individual #32 was intubated for a follow-up CT scan, and subsequently aspirated and developed pneumonia. His status deteriorated and he required a tracheostomy and gastric tube insertion. On 11/9/16, he was transferred to a LTAC facility, and on 12/1/16, returned to the Center. Based on the documents provided, it did not appear an acute care plan was developed and/or implemented.

- Missing IView documentation limited the Monitoring Team's ability to determine the steps nurses had taken with regard to Individual #46 – aspiration pneumonia on 11/16/16; Individual #162 - Acute nasopharyngitis and erythema around feeding tube on 12/16/16, and contact dermatitis to stoma site on 1/10/17; and Individual #10 - sepsis, hypophosphatemia on 1/12/17, and bronchitis on 2/14/17.

Outcome 2 – Individuals with chronic and at-risk conditions requiring nursing interventions show progress on their individual goals, or teams have taken reasonable action to effectuate progress.

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

#	Indicator	Overall Score	Individuals: 37	111	15	188	32	89	46	162	10
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	1/2	0/2	1/2	0/2	1/2	0/2	2/2	0/2	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 #37 – choking, and weight; Individual #111 – infections, and skin integrity; Individual #15 – aspiration, and fractures; Individual #188 – dental, and falls; Individual #32 – constipation/bowel obstruction, and diabetes; Individual #89 – GI problems, and urinary tract infections; Individual #46 – respiratory compromise, and circulatory; Individual #162 – GI problems, and seizures; and Individual #10 – diabetes, 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 #37 – choking, Individual #15 – fractures, Individual #32 – diabetes, and Individual #46 – respiratory compromise, and circulatory.

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: This is an area that requires focused efforts. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 37	111	15	188	32	89	46	162	10
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% 0/14	0/2	0/2	0/2	0/1	0/1	N/A	0/2	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. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, IDTs took immediate action in response to risk, or that nursing interventions were implemented thoroughly.

Some concerns noted included: missing IView documentation (i.e., the Monitoring Team often was only provided several days of IView documentation), IPNs that did not cover the entire time-period the Monitoring Team requested (e.g., Individual #162, Individual #10), and action steps that were not measurable.

b. The following are a few examples of changes of status for which IDTs did not take immediate action:

- After Individual #37's annual ISP meeting, he had three events of ingesting foreign bodies. The 8/22/16 ISPA did not document discussion about elevating his choking risk level to high due to the ingestion of inedible objects, which placed him at higher risk. This should have triggered modifications to his IHCP consistent with the need for increased level of supports to protect him from harm.

- No ISPA meeting notes were found after Individual #111 was diagnosed with C-Diff. The IDT should have met to develop a plan to meet her needs in isolation.
- Individual #15's ISPA, dated 12/16/16, to address his hospitalization for aspiration pneumonia stated: "PNMT PT reported there were no changes to his positioning schedule or precautions prior to hospitalization. It was noted that compliance with positioning and HOBE [head-of-bed elevation] may have been a contributor to his diagnosis." The ISPA did not show that the IDT took sufficient steps to prevent reoccurrence to the extent possible, and the IDT made no changes to the IRRF or the IHCP to address the lack of compliance with positioning instructions and head-of-be elevation requirements.
- On 2/14/17, Individual #188's IDT held an ISPA meeting for falls occurring on 12/28/16, 1/5/17, and 1/25/17. However, the action steps on which the IDT agreed did not include timeframes for completion, frequency, or persons responsible.
- In recent months, Individual #162's G-tube was dislodged on the following dates: 2/17/17, 11/16/16, 12/2/16, hospitalized 3/26/16 to 3/29/16 for dislodgement of tube, and 4/8/16. However, it did not appear that the IDT was meeting to discuss dislodgement of the tube, and to put in place preventive measures to minimize the risk. Moreover, it was unclear whether Behavioral Health Services staff had been involved to assess the situation, particularly given that Individual #188 did not want the tube.

Outcome 6 – Individuals receive medications prescribed in a safe manner.

Summary: For the three previous reviews, as well as this review, the Center did well with the indicators related to nurses following the nine rights, and implementing individuals' PNMPs. However, given the importance of these indicators to individuals' health and safety, the Monitoring Team will continue to review these indicators until the Center's quality assurance/improvement mechanisms related to medication administration can be assessed, and are deemed to meet the requirements of the Settlement Agreement. The remaining indicators will remain in active oversight as well.

#	Indicator	Overall Score	Individuals: 37	111	15	188	32	89	46	162	10
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R					N/A		N/A		
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 7/7	1/1	1/1	1/1	1/1		1/1		1/1	1/1
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or	100%	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	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.	1/1									
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	100% 3/3	N/A	N/A	1/1	N/A		N/A		1/1	1/1
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.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 5/5	N/A	1/1	1/1	N/A		1/1		1/1	1/1
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	57% 4/7	1/1	0/1	0/1	1/1		1/1		0/1	1/1
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	N/R									
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.	N/R									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/R									
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/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
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.	N/R									
Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the											

Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of seven individuals, including Individual #37, Individual #111, Individual #15, Individual #188, Individual #89, Individual #162, and Individual #10.

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

d. It was very good to see that for applicable individuals, the medication nurses assessed their lung sounds before and after medication administration through enteral feeding tubes.

f. It was also positive that for individuals observed, the nurses followed their PNMPs during medication administration.

g. For the individuals observed, some concerns were noted with regard to infection control practices. This included problems related to the use of aseptic techniques with G-Tube equipment, contamination of syringes used for extracting medications from larger bottles, and glove usage and glove exchange. These issues were discussed in detail on site with Nurse Managers who were part of the observations, and with the Chief Nurse Executive. The nurse member of the Monitoring Team suggested that nurses with the identified issues be further supported through re- training on infection control practices, and providing them with necessary equipment, such as a table to provide an area to work to avoid contamination of items, as well as disposable measuring cups for large amounts rather than the 30 cc medicine cups, and disposable syringes for obtaining measured amounts from large unit dose bottles.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: It was good to see individuals being referred to the PNMT, when needed. 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	37	111	15	188	32	89	46	162	10
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;	0% 0/9	0/1	0/1	N/A	0/2	N/A	0/1	0/1	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	44% 4/9	0/1	1/1		1/2		0/1	1/1	1/2	0/1
	iii. Integrated ISP progress reports include specific data	0%	0/1	0/1		0/2		0/1	0/1	0/2	0/1

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

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that seven individuals' IDTs were responsible for developing. These included goals/objectives related to: weight for Individual #37; falls for Individual #111; choking, and falls for Individual #188; fractures for Individual #89; fractures for Individual #46; aspiration, and falls for Individual #162; and skin integrity for Individual #10.

a.i. and a.ii. None of the IHCPs included clinically relevant, and achievable goals/objectives. 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 #111, falls for Individual #188, fractures for Individual #46, and falls for Individual #162.

b.i. The Monitoring Team reviewed eight areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goal/objectives were included. These areas of need included: aspiration for Individual #111; aspiration, and fractures for Individual #15; falls, and weight for Individual #32; aspiration for Individual #89; skin integrity for Individual #46; and aspiration for Individual #10.

b.ii. and b.iii. Working in conjunction with individuals' IDTs, the PNMT did not develop clinically relevant, achievable, and measurable goals/objectives for these individuals. Although the following goals/objectives were measurable, because they were not clinically

relevant, the related data could not be used to measure the individual's progress or lack thereof: fractures for Individual #15, falls for Individual #32, and skin integrity for Individual #46.

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 generally 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.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/17	0/1	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	18% 2/11	0/1	0/2	0/2	1/1	0/2	N/A	1/1	N/A	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% 0/7	N/A	N/A	0/2	N/A	0/2	0/2	0/1	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, many IHCPs included action steps that were difficult to measure (e.g., ongoing, "done," etc.).

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

- Individual #37's IDT had not developed strategies to address his weight gain. Between January 2016 and June 2016, he gained 12.4 pounds, and in the next six months, gained an additional eight pounds. As of January 2017, he weighed 191 pounds, and his estimated desired weight range was 128 to 156. This weight placed him in the category of obesity. However, there was no evidence of strategies to specifically address this issue.
- For Individual #111, upon her return from an LTAC, the PNMT conducted a review and determined that they would permit the IDT to conduct comprehensive assessments, and then the PNMT would review her in three months. However, the IDT therapists took 30 days to complete these assessments (i.e., in time for annual ISP), rather than completing them sooner based on the individual's change of status. A Head-of-Bed Evaluation (HOBE) was identified as needed, but the Center provided no evidence that one had been completed.
- It was good to see that when Individual #188 had three falls in less than 30 days, her IDT held and ISPA meeting to address this issue.

• No evidence was found that Individual #10's IDT held a post hospitalization ISPA meeting that included discussion of the hospital-acquired decubitus ulcer.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. On a positive note, when the Monitoring Team observed staff assisting individuals with transfers, the staff followed the PNMPs. However, positioning was of significant concern (i.e., 70% of individuals observed were not positioned correctly), and dining plan implementation remained a concern (i.e., staff did not follow dining plans during 27% of observations). 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 and Dining Plans correctly (e.g., competence, accountability, etc.), and address them.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	65% 24/37	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	43% 3/7	
Comments: a. The Monitoring Team conducted 37 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during three out of 10 observations (30%). Staff followed individuals' dining plans during 16 out of 22 mealtime observations (73%). Staff followed individuals' PNMPs during five out of five transfers (100%).			

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/1			N/A		0/1		N/A	N/A	N/A
Comments: a. Although Individual #32 returned to oral eating and the PNMT recommended a plan, his IDT had not developed a											

measurable plan.

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 the 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	37	111	15	188	32	89	46	162	10
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	60% 3/5	N/A	0/1	1/1	N/A	1/1	0/1	N/A	N/A	1/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	40% 2/5		1/1	1/1		0/1	0/1			0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5		0/1	0/1		0/1	0/1			0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5		0/1	0/1		0/1	0/1			0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5		0/1	0/1		0/1	0/1			0/1

Comments: a. and b. Individual #37 had functional motor and self-help skills, so a goal/objective was not indicated. Although Individual #188's IDT had not developed a goal/objective for her, they did discuss OT/PT strategies to reduce/prevent falls. Individual #46 and Individual #162 had PNMPs, but did not appear to need any other formal OT/PT supports or services.

The goal/objective that was clinically relevant and achievable, as well as measurable was the direct PT goal/objective for Individual #15. Although Individual #32's goal/objective for direct therapy (i.e., walking 100 feet) was clinically relevant, it was not measurable, including criteria for mastery (e.g., did he only need to perform the task once or over multiple trials?). Similarly, Individual #10's direct PT goal/objective was clinically relevant, but not measurable.

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

Individual #37, Individual #46, and Individual #162 were part of the core group, so full reviews were conducted for them as well. Individual #188 was at risk for falls, and her IDT discussed strategies to address her fall risk. Although she was part of the outcome group, a full review was conducted for her. As a result, the Monitoring Team conducted full reviews for all nine individuals.

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

Summary: The Monitoring Team will continue to review these indicators.

#	Indicator	Overall Score	Individuals: 37	111	15	188	32	89	46	162	10
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/6	N/A	0/1	0/1	0/1	0/1	0/1	N/A	N/A	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	25% 1/4	N/A	0/1	1/1	N/A	0/1	N/A	N/A	N/A	0/1

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented.

b. ISPAs generally were not found to show that IDTs met to discuss and approve/disapprove OT/PT recommendations to discontinue direct therapy.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: Given the importance of the proper fit of adaptive equipment to the health and safety of individuals and the Center's varying scores (Round 9 – 70%, Round 10 – 79%, and Round 11 - 80%), 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	117	118	28	40	89	16	127	70
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
b.	Assistive/adaptive equipment identified in the individual's PNMP is in proper working condition.										
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.	80% 16/20	0/1	1/1	1/1	1/1	1/2	1/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		129	107	54	4	58	187	6	111	115
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
		Individuals:									
#	Indicator		172								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								
Comments: c. Based on observation of Individual #90, Individual #40, Individual #16, and Individual #111 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. At the last review, one indicator was moved to the category of requiring less oversight. At this review, two other indicators, in skill acquisition will be moved to this category.

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

For the ISP personal goals that met criterion with ISP indicators 1 and 2, reliable and valid data about implementation were not available. The one exception was for Individual #111's goal about her day services, which had reliable data and for which she was making some progress.

SAPs did not have reliable data so that progress could be determined. For those SAPs for which the facility reported no progress, no actions were taken to modify the SAP. A new SAP training format was recently initiated and the Monitoring Team had the opportunity to meet with the staff who will be taking responsibility for improving the quality and implementation of SAPs at El Paso SSLC. Given all this, the Monitoring Team is optimistic about future improvement in this area between the time of this review and the next review.

El Paso SSLC regularly measured engagement and set goals for engagement. This was the case for some time now. Three of the nine individuals who were observed multiple times by the Monitoring Team were consistently engaged.

There was evidence that all of individuals participated in community outings and in community SAP training, however, there were no established goals for this activity.

It was positive to see that individuals observed had their AAC devices readily available. The Center should focus on ensuring that staff prompt individuals to use their AAC devices in a functional manner. In addition, the Center did not yet have a way to measure individuals' progress with regard to communication skills.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: One goal met criteria with indicator 3. Implementation and data are required if this set of indicators is to be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	156	111	37	153	15	32			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/5	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	0/5	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/5	0/6	0/6	0/6	0/6			
Comments: 4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. See Outcome 7, Indicator 37, for additional information regarding progress and regression, and appropriate IDT actions, for ISP action plans. For the personal goals that met criterion with indicators 1 and 2, there was no evidence that action plans to support those goals were consistently implemented because reliable and valid data were not available. The one exception was for Individual #111's goal about her day services, which had reliable data and for which she was making some progress.											

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: Staff knowledge greatly improved as reflected in indicator 39. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	156	111	37	153	15	32			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	67% 4/6	1/1	0/1	1/1	1/1	0/1	1/1			
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. Staff knowledge regarding individuals' ISPs was sufficient for four individuals, but for Individual #111 and Individual #15,											

insufficient to ensure the implementation of the ISP, based on observations, interviews, and lack of consistent implementation.

40. Action steps were not consistently implemented for all goals and/or action plans for any of the individuals, as noted throughout this report.

Skill Acquisition and Engagement

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

Summary: SAPs did not have reliable data so that progress could be determined. For those SAPs for which the facility reported no progress, no actions were taken to modify the SAP. These four indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
6	The individual is progressing on his/her SAPS	0% 0/16	0/2	0/1	0/1	0/1	0/1	0/3	0/3	0/2	0/2
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% 0/11	0/1	0/1	0/1	N/A	0/1	0/3	0/2	0/2	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	27% 4/15	1/2	0/1	0/1	N/A	0/1	0/3	1/3	0/2	2/2

Comments:

6. No individual had reliable data indicating he or she was making progress. Most of the SAP data indicated no progress. Some SAPs appeared to be progressing (e.g., Individual #161's shred paper SAP), however, the data were not demonstrated to be reliable (see indicator #5), so these SAPs were not scored as progressing. There was insufficient data to determine progress for Individual #156's chose a picture from her communication book SAP, however, it was scored as zero because the data were not demonstrated to be reliable.

8. None of the 11 SAPs judged as not progressing (e.g., Individual #179's complete household task SAP) had evidence that action was taken to address the lack of progress (e.g., retrain staff, modify the SAP, discontinue the SAP).

9. Overall, there was evidence of data based decisions to continue, discontinue, or modify SAPs for 27% of SAPs (e.g., Individual #153 was progressing in his count money SAP, and training was continuing).

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

Summary: A new SAP training format was recently initiated and the Monitoring Team had the opportunity to meet with the staff who will be taking responsibility

Individuals:

for improving the quality and implementation of SAPs at El Paso SSLC. Given all this, the Monitoring Team is optimistic about future improvement in this area between the time of this review and the next review. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
13	The individual's SAPs are complete.	0% 0/16	0/2	0/1	0/1	0/1	0/1	0/3	0/3	0/2	0/2

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. None of the 16 SAPs were judged to be complete. A common missing component was the absence of clear SAP training instructions. Many SAPs indicated that they utilized forward chaining, but appeared to utilize a total task methodology (e.g., Individual #37's identify money amounts SAP). The majority of the SAPs did not describe how to implement these training methodologies. Other common missing components were the absence of maintenance and/or generalization plans (e.g., Individual #112's use the telephone SAP), and the absence of a clear documentation methodology (e.g., Individual #111's use the sound machine SAP).

El Paso SSLC recently introduced a new skill acquisition training sheet and format. At the time of the onsite review, only one SAP developed in the new format was available to review (Individual #156's chose a picture from her communication book). The Monitoring Team was very encouraged by the quality of this SAP, compared to the SAPs with the older training sheets. The one component that was missing in the new format SAP, however, was a complete maintenance and generalization plan. A maintenance plan should specify how the team will ensure that the individual will continue the skill once they achieve it (e.g., once Individual #156 achieves this objective, she will be encouraged to use her communication system daily, etc.). A generalization plan should specify how the individual will generalize the skill to other areas of their life (e.g., once Individual #156 achieves this objective she will be encouraged to use her communication book in the workshop, in the community, and on home visits, etc.).

Outcome 5- SAPs are implemented with integrity.											
Summary: More work needs to be done to ensure that SAPs are implemented correctly. A SAP that was in the new format, however, was implemented correctly during direct observation by the Monitoring Team. Other attempts to observe were refused by individuals. These two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	161	179	60	156	111	112	159	37	153
14	SAPs are implemented as written.	100% 1/1	Attempted	N/A	N/A	1/1	N/A	Attempted	N/A	Could not rate	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/16	0/2	0/1	0/1	0/1	0/1	0/3	0/3	0/2	0/2

Comments:
14. The Monitoring Team attempted to observe the implementation of four SAPs. Individual #112 refused to participate in his use the telephone SAP. Similarly, Individual #161 refused to participate in her shredding SAP. The Monitoring Team did observe Individual #37's identify money amounts SAP, however, since the training instructions were not clear (see indicator #13), it was impossible to evaluate if the staff was implementing the SAP with integrity or not. The Monitoring Team observed Individual #156's choose a picture from her communication book SAP, and found that the DSP implemented the SAP as written, which was in the new SAP format.

15. El Paso SSLC established that each SAP would be monitored at least every six months and that IOA and integrity would be at least 80%. None of the SAPs had integrity assessments.

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

Summary: SAPs were not reviewed, data were not graphed, and little was done to evaluate progress. The new SAP work group, however, was planning to also address this need. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 161	179	60	156	111	112	159	37	153
16	There is evidence that SAPs are reviewed monthly.	0% 0/16	0/2	0/1	0/1	0/1	0/1	0/3	0/3	0/2	0/2
17	SAP outcomes are graphed.	6% 1/16	0/2	0/1	1/1	0/1	0/1	0/3	0/3	0/2	0/2

Comments:
16. Some SAPs were not reviewed in QIDP monthly reports (e.g., Individual #153's count coins SAP), others were reviewed, but only one month of SAP data was presented, which did not allow data based decisions concerning the need to continue, discontinue, or modify them (e.g., Individual #159's identify signs SAP).

17. Only Individual #60's point to her medication SAP had graphed data.

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

Summary: El Paso SSLC regularly measured engagement and set goals for engagement. This was the case for some time now and, therefore, indicators 19 and 20 will be moved to the category of less oversight. With continued focus, engagement may improve (indicators 18 and 21). These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 161	179	60	156	111	112	159	37	153
18	The individual is meaningfully engaged in residential and treatment sites.	33% 3/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	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. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found three (Individual #153, Individual #60, Individual #112) of the nine individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. 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 was 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.

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

Summary: There was evidence that all of individuals participated in community outings and in community SAP training, however, there were no established goals for this activity. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 161	179	60	156	111	112	159	37	153
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. El Paso SSLC 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: This indicator was moved to the category of less oversight during an earlier monitoring review.			Individuals:									
#	Indicator	Overall Score										
25	The student receives educational services that are integrated with the ISP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	N/A									
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	N/A									
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	N/A									
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	N/A									
e.	When there is a lack of progress, the IDT takes necessary action.	N/A									
Comments: Based on documentation reviewed, these individuals did not have refusals over the last 12 months.											

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 did not have a way to measure individuals' progress with regard to communication skills. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall	37	111	15	188	32	89	46	162	10

		Score									
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	13% 1/8	N/A	0/1	0/1	0/1	0/1	0/2	N/A	1/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	0% 0/8		0/1	0/1	0/1	0/1	0/2		0/1	0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/8		0/1	0/1	0/1	0/1	0/2		0/1	0/1
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/8		0/1	0/1	0/1	0/1	0/2		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% 0/8		0/1	0/1	0/1	0/1	0/2		0/1	0/1

Comments: a. and b. Individual #37 had functional communication skills. Individual #46 had a Staff Service Objective (SSO) to give her exposure to a talking picture album, so a goal/objective was not currently necessary.

The goal/objective that was clinically relevant was Individual #162's direct therapy goal/objective related to the use of his Talkable II.

c. through e. As noted above, Individual #37 had functional communication skills. He was part of the core group, so a full review was conducted for him. Individual #46 received communication supports through a SSO, so a full review was conducted for her. For the remaining seven individuals, the Monitoring Team completed full reviews due to a lack of clinically relevant, achievable, and measurable goals, and/or lack of timely integrated ISP progress reports analyzing the individuals' progress on their goals/objectives.

Outcome 4 - Individuals' ISP plans to address their communication needs are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	37	111	15	188	32	89	46	162	10
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/6	N/A	N/A	0/1	N/A	0/1	0/2	0/1	0/1	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Evidence generally was not found to support implementation of strategies and action plans.

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: During this review and the last one, it was positive to see that individuals observed had their AAC devices readily available. If the Center sustains this performance, Indicator a might move to the category requiring less oversight after the next review. The Center should focus on ensuring that staff prompt individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring. [**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	162	67	117	28	156	108	119	187	9
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	87% 13/15	1/2	1/1	1/1	1/1	1/1	1/1	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.	33% 5/15	1/2	1/1	0/1	0/1	1/1	0/1	0/1	0/1	0/1
			Individuals:								
#	Indicator		54	6	129	118					
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	1/1	1/1	1/2					
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		1/1	0/1	0/1	1/2					
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.	33% 1/3									
Comments: a. and b. It was positive that during most observations, individuals' AAC devices were present and readily accessible. The Center should focus on ensuring that when opportunities for using the devices present themselves, staff prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. Five indicators were moved to the category of requiring less oversight after the last review and all remain in that category. Five other indicators showed improved scores compared with the last review.

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 transition department continued to be well organized and very active. Six individuals transitioned to the community since the last review, which was twice the number compared with the time of last review, and six were on the active referral list, which was about half the number compared with the time of the last review. There were no re-admissions of individuals who had previously lived at El Paso SSLC.

Overall, continued improvement in the transition work done by the APC, transition specialist, post move monitor, and IDT team members was evident across all indicators in this domain. The transition department staff were very receptive to feedback from the Monitoring Team, had used feedback from previous monitoring reviews to improve their performance, and were very committed to successful transitions. Transitions were more individualized than even at the time of the last review.

Progress was evident in the number of CLDP supports that were written in measurable terms, and in the comprehensiveness of the list of pre- and post-move supports. The detail in the pre-move training supports had also improved, though more work was needed to get to criteria.

Post move monitoring continued to meet criteria, and was done thoroughly. The PMM conducted frequent visits to the homes and day programs to follow-up on needs as well as to periodically check in on individuals. The transition department appeared to have an excellent relationship with the community providers, while at the same time holding them to a high standard for service provision and documentation.

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, maintaining an accurate database of obstacles to referral for every individual at the facility, and attending ISP meetings to talk about community options. A good example of the latter was the transition specialist's comments and interaction with a parent/LAR at an annual ISP meeting observed by the Monitoring Team.

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: El Paso SSLC continued to make very good progress on both of these indicators. The transition department staff were responsive to the comments in the previous monitoring report and focused their attention on improving the wording of the supports and the comprehensiveness of the list of supports. This improvement was evident and, as a result, the facility moved much closer to meeting criteria with these two complex and important indicators. The areas that required some additional attention are detailed in the comments below. Focus on the details of the pre-move inservice training indicators might result in indicator 1 meeting criteria at the next review, and inclusion of the few aspects of pre and post move supports that were missing in these cases might result in indicator 2 meeting criteria at the next review, too. Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 116	24							
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:

1. IDTs must describe pre- and post-move supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how needs and preferences must be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to adjust as needed. At El Paso SSLC, the respective IDTs developed 31 pre-moves supports and 28 post-move supports for Individual #116 and 22 pre-move supports and 20 post-move supports for Individual #24.

Most of these supports provided specific and detailed information. For both individuals, examples of supports that fit this description of measurability included the pre- and post-move supports describing nutritional and diet requirements and for various quality of life preferences. Both individuals also had supports for monitoring of certain health conditions that included specific signs and symptoms staff needed to know. It was encouraging to see this level of detail and specificity in these examples.

Still, some pre-move supports did not provide the Post Move Monitor (PMM) with measurable criteria or indicators that could be used to ensure supports were being provided as needed. For example:

- Both Individual #116 and Individual #24 had a support for provider staff to be inserviced on their IHCPs. This was broad and vague and did not provide sufficient detail about the specific knowledge staff would be expected to have. In some instances, some of this information was found in other supports, but this was not consistent.

- Pre-move training supports for both individuals typically required a score of 80% on a written exam to indicate staff competency. The Monitoring Team appreciated the effort to quantify competency, but questioned whether this criterion could be appropriately applied in all instances. Concerns included:
    - A positive determination that staff knew 80% of the material they received training on would require they were tested on all the material. The written exams provided for review were very limited in scope and did not address many of the supports. They also often asked for broad answers, such as to name the health care plans, rather than testing for the specific details of what actions staff would need to take.
    - The IDT did not prioritize what staff knowledge would be essential versus information that could be considered optional. This was concerning because lack of staff knowledge in some areas could be life-threatening, yet it was conceivable a staff person could obtain a passing score and be considered competent even if they did not answer essential questions correctly.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was positive they had made a diligent effort to address their needs. The Monitoring Team noted the Center's use of a template that guided the IDTs to consider a broad array of possible supports. The IDTs used this with good success in many instances, as described below, to ensure supports were considered in all areas. Some also included substantial detail as described above under indicator 1. The Monitoring Team encouraged the Center to make sure it individualized all template areas to the same degree, and to avoid relying too heavily on standardized language.

a. Past history, and recent and current behavioral and psychiatric problems: For both individuals, supports called for pre-move training related to behavioral needs, but did not specify the training methodologies or competency demonstration criteria. Neither of these individuals had recent histories of significant behavioral and/or psychiatric needs. Neither had a Positive Behavior Support Plan (PBSP) or received psychotropic medications at the time of transition. It remained important, however, for IDTs to describe behavioral histories and needs that might recur or become exacerbated with a change in living environments. Examples included:
    - Individual #116 sometimes displayed self-injurious behavior by biting her hands when her space is disturbed or her environment is extremely loud. It was positive the IDT included supports for staff knowledge of this behavior and how to respond with verbal re-direction or a change of environment. Individual #116 was also known to push her peers when she became agitated or as a means of escaping the immediate environment. The behavioral/psychological summary in the CLDP narrative stated a recommendation that Individual #116 should continue to develop functional communication skills to excuse herself or to get others to leave, rather than to push her peers. It suggested she could learn to tap someone on the shoulder to get his or her attention. The IDT did not develop any related supports for staff knowledge of this history or for implementation of this strategy.
    - Individual #24's IDT had discontinued her Psychiatric Support Plan (PSP) on 8/5/15. Her most recent IRRF, dated 3/1/16, included recommendations to have the QIDP create a log for tracking the following refusals: eating meals, self-feeding, wearing shoes, getting out of bed, walking, using her gait trainer, etc. It also proposed strategies for addressing refusals, to include using a firm tone and directive statements and to allow her extra time before asking again. The CLDP narrative noted in some places that she sometimes refused activities. The Residential summary also

indicated she could become aggressive if she is upset or refuses to do something or go somewhere. Neither the CLDP narrative or assessments provided any updated status and the IDT did not develop any related supports for staff knowledge of this history or intervention strategies.

b. Safety, medical, healthcare, therapeutic, risk, and supervision needs: As described above under indicator 1, the respective IDTs had developed many detailed supports for both individuals related to safety, medical, healthcare, therapeutic and risk needs. This was positive. Additional improvements continued to be needed to achieve compliance with this criterion. For example:
   - Both individuals had an overly broad pre-move support for provider staff inservice for their respective IHCPs, as described in indicator 1 above. For Individual #116, the CLDP included additional supports that called for specific staff knowledge of signs and symptoms of health concerns, including weight, bowel movements, hypothyroidism, bronchitis and gastritis. This was positive, but this still did not cover all her IHCP needs. Individual #24's CLDP did not include similar additional supports.
   - For Individual #116, additional examples included:
     - The 14 Day referral ISPA stated she needed a nurse on call 24/7 to be seen as needed for respiratory issues or other medical concerns. The CLDP did not include any specific support about the level of nursing access or monitoring required.
     - The pharmacy assessment indicated the preferred medication administration methodology was crushed and incorporated into applesauce/pudding, with no more than three pills at a time. The CLDP included a pre-move support that stated medications were to be crushed in a food vehicle of choice, such as chocolate pudding or applesauce, but did not state the precaution that no more than three pills should be crushed at a time. This was also true for the related post-move support.
   - For Individual #24, additional examples included:
     - The CLDP did not include a specific support related to the use of her Vagus Nerve Stimulator (VNS), although her medical assessment indicated staff must be aware of the VNS and how to use it if needed. Instead, it was included in a listing of adaptive equipment with a note to use per nursing care plan. This support should have included specific indications for both how and when to use it, as well as how to ensure its upkeep and operability. The written inservice exams did not address how the VNS would be used.
     - Individual #24's IDT did not develop any specific support about the level of nursing access or monitoring required.

c. What was important to the individual: The Center did a particularly good job of describing supports for quality of life preferences for both individuals. Each individual had several pre-move inservice training supports in this area and corresponding post-move supports for implementation. These supports did need to be more specifically stated as to the expectation for how frequently they might occur. This specificity was left to the PMM to define through the development of checklists, but the supports themselves should include this information.

d. Need/desire for employment, and/or other meaningful day activities: Both CLDPs had a virtually identical support stating they would be provided with a day program and a daily schedule that was flexible and included various items, balls, activities, outing and community excursions as identified in the respective recreation summary. Both also included access to a quiet area they

could enjoy if they did not wish to participate. These were not clearly individualized and perhaps an example of reliance on standardized language. Other supports addressed specific community activities each enjoyed and these were more individualized, to an extent, but did not specify any expectation for how frequently they might occur. Instead they indicated this would be found in checklists to be developed by the PMM. As described above, the supports should include this information.

e. Positive reinforcement, incentives, and/or other motivating components to an individual's success: Overall, these CLDPs focused considerable attention on activities and environmental factors that would contribute to a successful transition, which was very positive to see. The Monitoring Team would again encourage the IDTs to make some of these supports clearly measurable, including such information as how frequently the provider would make preferred activities available. For both individuals, the IDTs had additional opportunities to define positive reinforcement strategies to address potential behavioral issues, as described above in sub-indicator a. For Individual #116, the IDT did define some strategies, but could have also considered the recommendation that she continue to develop functional communication skills to excuse herself or to get others to leave, rather than to push her peers. For Individual #24, the IDT did not develop any supports related to strategies for addressing refusals, to include using a firm tone and directive statements and to allow her extra time before asking again.

f. Teaching, maintenance, participation, and acquisition of specific skills: The Monitoring Team reviews individuals' ISPs, PSIs and other assessments to evaluate whether the IDTs developed supports related to teaching, maintenance, participation, and acquisition of specific skills that corresponded to identified needs and recommendations.
    - The IDT for Individual #116 developed such supports and met criterion. Supports included learning to sign for toileting, bathing skills, and a mobility program. As described above, the behavioral health assessment also recommended learning to develop functional communication skills to excuse herself or to get others to leave, rather than to push her peers, such as learning to tap someone on the shoulder to get their attention. While criterion for this sub-indicator was met, it would have been positive to see the IDT address this in the CLDP as well.
    - Individual #24's IDT included supports for staff training and implementation of a mobility program, but did not provide any specific detail as to how or when the program was to be implemented. The Monitoring Team did not observe specific staff training regarding the mobility or any reference to it in the written competency exams. The CLDP did not include any other supports related to teaching, maintenance, participation, and acquisition of specific skills.

g. All recommendations from transition assessments are included; or if not, there is a rationale provided to justify non-inclusion: Recommendations from assessments were frequently addressed, but this was not yet consistent. Sometimes clinicians embedded recommendations in their assessment narratives, but did not carry them through to the recommendations section. This resulted in important recommendations not being carried over to the CLDP discussion and/or included in CLDP supports. For example, for Individual #116, the nursing assessment narrative noted the recommendation for maintenance of aural hygiene through periodic otoscope inspection and removal of cerumen. The CLDP discussion included that information in the summary, but did not carry it through to the listed recommendations. The CLDP did not include a specific related support, even though the narrative indicated all the recommendations were agreed upon by the IDT and would be included. Other examples of recommendations not included or otherwise justified included:
    - For Individual #116:

- Both the social/QIDP assessment and the residential assessment recommended communicating with Individual #116 before approaching her. The IDT did not address this in the pre-or post-move supports, although the narrative indicated this recommendation would be included.

- For Individual #24:
  - As described above, the medical assessment recommended provider staff should be aware of her VNS and how to use it, but the CLDP did not address this specifically.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Post move monitoring continued to be conducted as required. The PMM was thorough and conducted additional visits to ensure supports were provided and any problems were followed to resolution. Five of these eight indicators were moved to the category of requiring less oversight for this review. In order to maintain this categorization, the PMM and transition department staff need to attend to the comments below in indicators 4, 6, 7, and 8. Indicator 5 will remain in active monitoring. Indicators 9 and 10, regarding Monitoring Team observation of post move monitoring might be moved to the category of requiring less oversight if high performance is sustained, after the next review. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	116	24							
3	Post-move monitoring was completed at required intervals: 7, 45, 90, and quarterly for one year after the transition date	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	Reliable and valid data are available that report/summarize the status regarding the individual's receipt of supports.										
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 assessment is correct based on the evidence.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.										
8	Every problem was followed through to resolution.										
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	100% 1/1	N/A	N/A							
10	The PMM's report was an accurate reflection of the post-move	100%	N/A	N/A							

	monitoring visit.	1/1									

Comments:
Indicators 3, 4, 6, 7, and 8 received less oversight during this round. Comments for these five indicators are provided, but these indicators were not scored.

3. Post-move monitoring was completed at required intervals, and all locations were visited for both individuals. The PMMs provided considerable detail in their comments regarding the provision of supports, which was very helpful for understanding the status of each transition.

4. Reliable and valid data were available regarding the status regarding the receipt of most supports. The Center will need to continue to work on improving the measurability of supports so that they define what data need to be collected. For both individuals, it was not always possible to ascertain whether reliable and valid data were present, due in part to a lack of specificity and measurability of some supports as described in indicator 1. This was particularly true for the supports calling for staff to be knowledgeable of the individuals' IHCPs. Improving the measurability and specificity of the pre-move inservice supports will make it easier for the PMMs to know what data are needed to demonstrate that these are fully in place.

5. Based on information the Post Move Monitor collected, one of the two individuals had consistently received supports as listed and/or described in the CLDP, as detailed below:

- Individual #116 had not received some of the supports as listed and/or described in the CLDP. Examples included:
  - At the time of the 90 day PMM visit, she had not yet had several past-due appointments, including neurology, urology, cardiology and pulmonary.
  - She had not been taken to get a haircut as indicated.
- Individual #24 received supports as listed and/or described in the CLDP.

6. The PMM's scoring was generally correct. Additional improvements that could be made as follows:

- For Individual #116, the PMM made certain adjustments to the timelines for some medical consultations, including dental and gynecology, based on reviewing physician notes from the Center that indicated a later due date than the 30-day expectation set by the IDT. Based on these, she indicated some supports were not yet applicable rather than not in place. The PMM should be cautious about making those changes without consulting with the IDT and gaining its approval.
- For Individual #24, based on the information collected, the PMM's scoring was generally correct. Even so, some supports were overly broad, such as post-move support 7A, for which the PMM documented that all the adaptive equipment was available per her observation. It was not clear how the PMM evaluated the use of the VNS, given the support only indicated it would be used per nurse care plan. Similarly, there was no specific evidence the PMM interviewed staff about the purpose of the voice alert system or whether they had had any occasion to respond to it.

7- 8. The Post Move Monitors were very diligent in their efforts and provided very complete documentation in most cases. The following improvements that should be considered:

- The Center's protocol for requiring IDT review of PMM findings, including supports that had not been provided, relied on the PMM to make that determination. The Center may want to consider strengthening that protocol and perhaps requiring IDT

input whenever significant health care and/or safety supports are not in place. For instance, some supports for Individual #116 for a urology appointment, due at 30 days had not occurred at the 90 day, but she had already been hospitalized for UTI and renal failure.

- For purposes of ensuring follow-up, the Center may also wish to consider a protocol for incorporating post-move recommendations for new or modified supports, such as those developed as a result of PDCT events, into the monitoring process.

9-10. The Monitoring Team reviewed the conduct of the 45 day post move monitoring for Individual #21. Post move monitoring and the post move monitoring report were done for her day program and for her home. The Monitoring Team observed at both locations and reviewed the completed report for both locations. Post move monitoring was conducted thoroughly and all relevant supports were explored at both locations. Overall, she was doing well in her new day program and home.

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

Summary: Both individuals had a negative event occur. One was very serious, the other not so. In both cases, some supports, that if they had been in place, would have reduced the likelihood of both events occurring. As noted below in the comments, the El Paso SSLC transition department and IDT staff took exceptional steps once these events occurred to ensure that the individuals were safe. This indicator will remain in active monitoring			Individuals:								
#	Indicator	Overall Score	116	24							
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.	0% 0/2	0/1	0/1							

Comments:

11. Both individuals had experienced a PDCT event.
    - Individual #116 was hospitalized with a UTI, dehydration, and renal failure, approximately two weeks after transition. Per the documentation, she had started to eat and drink less at each meal, beginning on the eighth day. She was seen by the physician on that day and by the provider nurse on 9/29/16 and 9/30/16 (Thursday and Friday,) but was refusing to eat and drink by that time. Over the weekend, she continued to refuse, but documentation did not indicate the provider nurse was contacted. On that following Monday (10/3/16), Individual #116 was hospitalized. She continued to refuse to eat throughout the hospitalization, despite concerted efforts by the Center's IDT to assist hospital personnel to address this need. Individual #116 was released from the hospital on 10/10/16, per her guardian's request, but had not yet begun eating.

She returned to her new home and El Paso SSLC staff visited and re-trained provider staff. The PMM visited every other day for the following three weeks, alternating between the home and day program to monitor. Since that time, Individual #116 recovered fully. The Monitoring Team commends the PMM and IDT for providing this level of attention and follow-up to ensure Individual #116's recovery and adjustment.

Even so, this indicator requires review of transition planning as relevant to this event.

- The IDT noted issues that were identified prior to the move, including Individual #116's history of UTI, her reluctance to drink liquids, and the need for staff to thicken her liquids outside of her vision.
- Other factors the IDT should have considered included:
  - The CLDP included supports to be offered plenty of liquids daily, but it did not include any requirement for tracking her fluid intake.
  - The CLDP had a support for all staff to be trained on her IHCPs, but this support was too broad and vague to be easily monitored to ensure its implementation or even staff knowledge. It was not possible to ascertain staff knowledge at the time of her transition. The written exams for habilitation, nursing, residential, and modified textures did not address the need to modify her liquids out of her sight. The written medical/nursing exam did not reference her history of UTI.
  - There was not a specific support regarding the need for liquid thickening to be done out of her sight.
- In addition to actions taken by El Paso SSLC staff described above, the IDT identified decisions and recommendations as a result of the PDCT meeting, which took place on 12/9/16 (approximately two months later). The Center did not have a process in place for ensuring these were incorporated into the PMM monitoring process for Individual #116, but needed to do so. These decisions included:
  - Liquid intake should be logged and staff should report any changes in her food and liquid intake and urine should be reported immediately.
  - For refusals to eat/drink, action should take place within two days.

- The provider took Individual #24 to the emergency room (ER) as a precautionary measure after she fell out of bed and hit her head. Per the documentation, a required voice alert device was in place, but by the time staff got to her room to check on her, she had already fallen. Trying to get out of bed by herself was a known risk factor for falls. Per her ISP, Individual #24 had sustained six falls in the previous ISP year and three falls for the current ISP year. All falls had occurred when she got up unassisted from her bed or chair.
  - The IDT met on 2/17/17 to review. The IDT did not clearly indicate whether supports were designed to have reduced the likelihood of this type of event occurring, but did document its assessment that nothing could have been done differently. The documentation stated that all measures and supports were in place, such as a voice alert device, alarms, and staff checks every 15 minutes. The CLDP had identified supports for a voice alert device to be used in bed to notify direct support staff to provide assistance and chair alarms to be used at other times. The CLDP did not specify a support for 15 minute checks as the PDCT documentation indicated, although it was possible the provider had implemented this.
  - The IDT should approach the PDCT meeting as an opportunity to address remedies for the current issue as well as for quality improvement for future transitions. This was good to see.

- This indicator was not scored as meeting criteria for Individual #24 because:
  - The adequacy of the pre-move inservice and demonstration of staff competency related to the risk of falls. The IDT did not examine the adequacy of the pre-move inservice and staff competency related to this risk, but should have. As described in Indicator 14 below, the written exam did not explicitly address knowledge of falls prevention supports; rather, it asked provider staff to list risk areas. Of the three written exams, all identified falls as a risk, but only one identified that staff needed to be aware of her wanting to get out of bed as a factor.
  - The CLDP had identified supports for a voice alert device to be used in bed to notify direct support staff to provide assistance and chair alarms to be used at other times. The CLDP did not specify a support for 15-minute checks as the PDCT documentation indicated.
  - In interview, transition staff noted her room was located at the end of the hallway furthest from the living area. This might have been an important consideration in assessing the setting prior to the move. The PDCT documentation did not indicate the IDT further explored why staff had not been able to reach Individual #24 after the voice alert device was activated. In interview, transition staff noted Individual #24's room was located at the end of the hallway furthest from the living area. This might have been an important consideration in assessing the setting prior to the move, or possibly for a room change after the event occurred.

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. Improvements were seen, but more work is needed to get transition assessments to meet criteria. It was good to see comments/documentation of IDT discussion of what is required for indicators 15-17, though some additional rationale for the IDT's decision is needed to meet criteria. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	116	24							
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	100% 2/2	1/1	1/1							

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

Comments:

12. Assessments did not consistently meet criterion for this indicator. The Monitoring Team considers four sub-indicators when evaluating compliance.

- Assessments updated with 45 Days of transition: Available discipline assessments were completed within 45 days of transition.
  - The Center did not review or update the Integrated Risk Rating Form (IRRF) for either of the individuals, but should have, or should have indicated that the IRRF was reviewed and no updates were required. The IRRF section of the ISP typically contains a great amount of information. In interview, the APC indicated the IDTs have begun reviewing the status of the IRRF as part of the transition assessment process. This was a positive step.
  - For Individual #24, the Center did not provide an updated pharmacy assessment for review.
  - The Center did not routinely update the Functional Skills Assessment (FSA) for either individual. For both, the FSA provided for review had not been updated within 45 days prior to transition, but should have been. The Center did update a residential summary for transition, but this did not include the same level of detail about skill acquisition needs as the FSA would provide.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Available assessments generally provided a summary of relevant facts of the individuals' stay at the Center, which was positive. Overall, scoring of this factor was impacted by the missing updated assessments and so did not meet criterion.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Some assessments provided good detail and addressed supports needed to ensure a successful transition and supports that may need to be individualized in the community setting. Some assessments did not

offer recommendations that were individualized or specific. For example:

- For Individual #116, the recommendations from the educational summary were very broad. They included to have the individual engage in different activities, to continue to attend day programming, and to continue to have a structured routine.
- For Individual #24, the recommendations from the residential summary were very broad. They consisted of continuing to follow her PNMP, for her parents to continue to be part of her life, and to continue promoting her independence.

- Assessments specifically address/focus on the new community home and day/work settings: The broadness of the recommendations described above kept those assessments from meeting criterion for this sub-indicator.

13. The Monitoring Team considers three sub-indicators when evaluating compliance related to transition documentation for this indicator, including the following: (1) There was documentation to show IDT members actively participated in the transition planning process, (2) the CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (3) the CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.

- IDT members actively participated in the transition planning process: There was documentation to show IDT members actively participated in the transition planning process.
- The CLDP specified the SSLC staff responsible for transition activities, and the timeframes in which such actions are to be completed: Both CLDPs met criterion for this sub-indicator.
- 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: Criterion was met for this sub-indicator for both individuals.

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: All measurable training supports should include detail about who needs to be trained, the training methodology required, the competency criteria and how those competencies will be demonstrated. It was positive the IDTs had begun to describe the type of training needed.

Most of the time, didactic/classroom training was indicated, but the IDT's also occasionally indicated the training would include a video or demonstration as appropriate.

The Center had also made an effort to describe the competency criteria by requiring a paper exam and specifying a minimum passing score of 80%. This was a good beginning, but the IDTs should further consider whether other forms of competency demonstration may be needed (e.g., return demonstration) and whether a score of 80% on a written exam would always indicate adequate knowledge. This latter consideration should take into account whether the exam covered all of the important information provider staff needed to know. The following example is for Individual #24, but the concerns are also applicable to Individual #116's training.

- Individual #24's nursing inservice competency tests were minimal. Per the CLDP, provider staff were to be inserviced on all of Individual #24's IHCP risks and concerns that would require reporting to provider clinicians. The type of training was defined as didactic/classroom with a paper exam to be given at the end. A score of 80% was required.
  - Her IHCPs included the following: choking/aspiration; G.I./reflux precautions; dental care; cardiac; weight

maintenance; falls and fractures; infections; and, neurologic/seizures. The medical/nursing CLDP competency exam had a total of six questions, which consisted of naming the healthcare plans for the individual; naming her psychiatric diagnosis (none); naming the level of intellectual disability; naming the individual's diet requirements, food texture and liquid consistency; naming at least three medications the individual is taking and the condition they are prescribed for; naming the allergies the individual may have. The competency exam appeared to be a standardized template and covered a lot of information, but did not cover many of the specific supports needed to maintain Individual #24's health and safety. As such, it did not serve to demonstrate provider staff knowledge of all the many IHCP supports.

  - In addition, in many cases, provider staff did not fully or accurately answer the six questions, yet were marked as achieving 100%. For example, three competency exams were provided. Of these, in response to the question asking staff to name Individual #24's health care plans, two indicated only that she had a GI health care plan, while the third indicated her plan was Medicaid/Medicare.

- Individual #24's habilitation competency exam was also comprised of six questions. The last question was to name her risks, or what staff needed to look out for, per her PNMP. Provider staff all noted her risks included falls, but only one individual noted staff needed to be aware that she wants to get up by herself, which was the most significant factor in her risk for falls.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The CLDPs for both individuals included a statement by the IDTs that they had discussed whether any such collaboration was needed and agreed that it would be sufficient to share the facility clinicians' contact information with the provider. It was positive the CLDP documented this discussion. It would be helpful if the IDTs also documented their rationale for this statement.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results: The CLDPs for both individuals included a statement by the IDTs that this question was posed to the IDT and it agreed that the pre-site certification that all supports were in place would suffice. This did not clearly address the issue of whether any settings assessments were needed. For Individual #24, per an ISPA dated 8/23/16, the IDT asked habilitation therapy to visit the home prior to the completion of home modifications to provide input related to the roll-in shower. The ISPA documented the OT representative would be available to visit the home before the modifications were complete "if asked." The Center did not provide any additional documentation about this need or how this was resolved, but indicated in interview that the OT reviewed pictures of the home taken by the PMM. It would have been preferable to see clear documentation that this satisfied the IDT's initial request.

17. The CLDP should provide a specific statement about the types and level of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences. Examples include provider direct support staff spending time at the Center, Center direct support staff spending time with the individual in the community, and Center and provider direct support staff meeting to discuss the individual's needs.

The CLDPs for both individuals included a statement by the IDTs that it had discussed whether any such activity was needed. It was positive the CLDP documented this discussion. The IDTs should provide in the statement sufficient detail to ensure any identified needs are followed-up. For example, for Individual #116, the CLDP stated her IDT discussed the question posed to them and agreed that all they would need were some pictures for the team to view. The PMM was to take the pictures and share with the team. The CLDP did not indicate what pictures were needed and whether/how this addressed this question. This was not included in the pre-move

supports, but should have been. In interview, transition staff indicated the pictures were taken and shared with the IDT, which was positive. In the future, the Center is likely to meet criterion for this indicator if it specifically documents what actions need to be taken and indicates how they have been or will be tracked to completion.

18. Overall, the APC and transition department staff collaborated with the LIDDA staff when necessary to meet the individual's needs during the transition and met criterion. Documentation indicated the LIDDA participated in both CLDPs and in the development of the HCS plans of care. The LIDDA did not participate in either of the PDCT meetings, but Center staff did invite them. The APC noted that the LIDDA did not routinely notify the Center who the HCS Service Coordinator will be for individuals who transition, which limited the potential for any post-move collaboration that may be needed. It would be worthwhile for Center transition staff to make a continuing effort to obtain this information and keep those lines of communication open.

19. The Pre-Move Site Reviews (PMSRs) for both individuals were completed in a timely manner and each indicated all supports were in place. In both instances, however, the pre-move supports were all defined as pre-move provider training for various topics requiring that trainees pass a paper exam with a score of at least 80%. Each of these supports was marked as present, presumably based on the delivery of the training and successful completion of the paper exams, but the PMM did not include any comments addressing staff knowledge and competence. This was concerning based on the minimal nature of the paper exams as described in indicator 14, which did not provide sufficient evidence of staff knowledge of the breadth of supports required.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Individuals received lots of attention once referred and, as a result, transitions did not stagnate. This indicator was scored at 100% for this review with sustained high performance might be moved to the category of requiring less oversight after the next review.

#	Indicator	Overall Score	Individuals: 116	24							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 2/2	1/1	1/1							

Comments:

- Individual #116 was referred on 3/8/16 and transitioned on 9/19/16, just slightly more than 180 days. The transition process was well documented and proceeded at a reasonable pace.
- Individual #24 was referred on 4/10/15 and transitioned on 1/17/17, or about 21 months later. According to the Transition Specialist Log, which was very detailed, it took some time for the provider to locate a home that would meet Individual #24's needs, and her LARs' preferences, and then to make the necessary modifications. The process was well documented. The Monitoring Team noted the Transition Specialist found it necessary to follow up with the IDT several times to schedule overdue 180 day monthly meetings, but there was no indication this had any negative impact on the timeliness of the transition.

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

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

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

The individual-specific documents listed below:

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

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

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

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

The individual-specific documents listed below:

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

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