United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

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Submitted By: Alan Harchik, Ph.D., BCBA-D
Maria Laurence, MPA
Independent Monitors

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

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Background

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

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

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

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

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

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

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

Methodology

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

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

Organization of Report

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

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

Executive Summary

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

The Monitoring Teams wish to acknowledge and thank the individuals, staff, clinicians, managers, and administrators at 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. Twenty-four of these, in restraint management and in incident management, and quality assurance, were moved to, or were already in, the category of requiring less oversight after the last review. During this review two 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 and incident management. Two indicators, in quality assurance (DUEs), however, were 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.

<u>Restraint</u>
The director of behavioral health services was very knowledgeable about restraint and restraint data. Restraint was reviewed or presented in meetings with the Monitoring Team, in restraint reduction committee, and in QAQI Council.

In general, there was a high level of acceptable performance on indicators 1-17. One area for improvement is that there was no pre-restraint behavioral services consultation for the one crisis intervention chemical restraint that was reviewed (there were only two crisis intervention chemical restraints during the entire review period). Another area for attention is the occurrence of injuries (albeit non-serious) during crisis intervention restraint.

El Paso SSLC changed to a frequency count rather than an episode count in July 2017, making it impossible to compare data over the past three years. Many of restraints at El Paso SSLC occurred consecutively. It is important to have a frequency count of

every restraint, but the Center can also chart episodes if that might be helpful to their own analyses; some of the other Centers are doing that.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: monitoring individuals for potential side effects of chemical restraints; providing follow-up for abnormal vital signs, as well as injuries; 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

Since the last review, a new Incident Management Coordinator (IMC) and a new facility investigator were appointed. Both were very experienced with a number of years working at El Paso SSLC. They were reported to have been trained and credentialed by a reputable national training program in investigations.

In general, even with a new IMC and new investigator, center follow-up to DFPS cases was very thorough, and, facility-only investigations were very thorough. El Paso SSLC continued to regularly review trends, and supports/plans were in place to have reduced the likelihood of the incidents occurring (indicator 1).

All incidents were reported properly, with one exception. This was for an incident in which the reporter was unknown, but there was no attempt by the investigation to determine if the caller was the individual, staff, or someone else. Digging deeper to make this determination should become typical for these types of allegations.

Non-serious injury investigations were not occurring when they should have occurred and/or they were not done properly.

Various data were collected regarding allegations, findings, injuries, and unusual incidents. A format existed for presentation of the data. This was good to see, however, more work was needed in the depth of the analysis. The Monitoring Team recommends that the IMC obtain assistance from the State Office discipline coordinator.

Other

Many individuals received pretreatment sedation or general anesthesia for medical or dental procedures. Although various informal protocols were described, they were not being done in an organized manner so that, for example, progress could be determined. Although some positive effects were reported for four individuals who no longer needed general anesthesia, the majority of individuals at El Paso SSLC continued to receive this level of sedation.

Due to the fact that since the last review, timely quarterly DUEs were not completed, the related indicators will return to active oversight.

Restraint

Outcome 1- Restraint use decreases at the facility and for individuals.

Summary: El Paso SSLC changed to counting frequency of crisis intervention restraints rather than episodes in July 2017. This made it impossible to look at the long-term trend, however, it was good that they were now counting every occurrence. The Center can, if it wants to, also graph episodes. An episode count may be of use for their own analysis of restraint usage. Overall, the rate of crisis intervention restraint since July 2017 was not decreasing (primarily crisis intervention physical restraint). There were few (only two) instances of crisis intervention chemical restraint and no instances of crisis intervention mechanical restraint. Fewer individuals had crisis intervention restraint than at the time of the last review and none had protective mechanical restraint for self-injurious behavior. For medical and dental procedures, there was no use of restraint, little use of pretreatment sedation, and decreasing use of general anesthesia (El Paso SSLC does not use TIVA). The decrease in use of general anesthesia for some individuals requires some additional analysis by the Center, but appears to be at least in part related to informal desensitization strategies and the use of their desensitization clinic. Nevertheless, most individuals at El Paso SSLC received general anesthesia (more than 80%). One other area for attention is the occurrence of injuries during crisis intervention restraint as noted in the comments below. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
1	There has been an overall decrease in, or ongoing low usage of, restraints at the facility.	75% 9/12	This is a facility indicator.								
2	There has been an overall decrease in, or ongoing low usage of, restraints for the individual.	70% 7/10	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1	0/0

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (March 2017 through November 2017) were reviewed. In July 2017 (mid-way through the nine-month review period), the Center changed its count of restraints from episodes to frequency. This made it impossible to look longitudinally at the trend in the frequency of crisis intervention restraints. However, when looking at the frequency for the five-month period since July 2017, a decrease was not evident and the census-adjusted rate was one of the highest in the state. It is important for every restraint to be counted and it was good to see that Center was doing so. In addition, although not requested by the Monitoring Team, the Center might want to also graph episodes per month because this might be helpful to have as part of their own analysis of restraint. Some of the other Centers are already doing this. For instance, in the tier 1 document .15 that

listed restraints for six months, there were 148 separate restraints that occurred within 60 episodes. The Monitoring Team would be open to receiving this information in future reviews and learning about the Center's analysis of those data, too.

The trend of frequency of crisis intervention physical restraints paralleled the overall use of crisis intervention restraint because the vast majority of crisis intervention restraints were crisis intervention physical restraints. The average duration of a crisis intervention physical restraint was less than two minutes (looking at data since July 2017), the second lowest in the state. There were two occurrences of crisis intervention chemical restraint, the same low number as last time, and no occurrences of crisis intervention mechanical restraint. No individuals had protective mechanical restraint for self-injurious behavior and the number of individuals who had a crisis intervention restraint each month (three to four) was lower than at the time of the last review (five to six).

The number of injuries reported to have occurred during restraint remained high, with one injury indicated as a serious abrasion and bump to head. The Center should review restraint practices to ensure that they are done correctly. The number of injuries was higher than at any other Center. El Paso SSLC should talk with the state office discipline coordinator for restraint to ensure that they are recording the frequency in the same way that other Centers are recording this frequency. For instance, on the list of restraint injuries (tier 1 document .18), there were some duplicate entries for the same non-serious injury on the same day in which there were multiple consecutive restraints. It may be that there were multiple injuries, or it may be that the recording system included the same injury multiple times.

There were no instances of the use of non-chemical/non-medication restraints for medical or dental procedures. There were no uses of pretreatment sedation for medical or dental procedures. The use of general anesthesia (GA) for dental procedures was less than at the time of the last review (El Paso SSLC does not use TIVA, even though some of the graphs and data tables were labeled as TIVA). The Center reported implementing a variety of informal strategies to increase individuals' comfort with dental procedures. This included use of their specialized room for dental desensitization, primarily frequent non-threatening exposure to dental procedures. The Center reported that four individuals no longer needed GA due to these strategies. Even so, most individuals received GA at El Paso SSLC, that is, more than 80%. The Center also reported that no individuals went off-campus for TIVA or for general anesthesia.

Thus, facility data showed low/zero usage and/or decreases in nine of these 12 facility-wide measures (i.e., duration of crisis intervention physical restraint, use of crisis intervention chemical and mechanical restraint, use of protective mechanical restraint for self-injurious behavior, number of individuals who had crisis intervention restraint, use of non-chemical restraints for medical/dental procedures, use of pretreatment sedation for medical/dental procedures, and use of GA/TIVA.

Restraint reduction committee was meeting regularly. The director of behavioral health services was very knowledgeable about restraint and restraint data. At the committee meetings, all occurrences of crisis intervention restraint were reviewed. In addition, Center-wide data, such as some of the 12 sets of data reviewed in this indicator were presented as was information related to some of the other outcomes and indicators that are monitored by the Monitoring Team. Restraint reduction committee provides a good forum for analyzing trends, identifying possible variables, and creating actions. During the meeting held during the onsite review week, lots of data were presented, which was good to see, however, there was no discussion or participation from attendees. The Monitoring Team suggests that data sets 9-12 also be reviewed by the committee.

2. Four of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, one restraint for Individual #13 was also included in this review. Of these, four received crisis intervention physical restraints (Individual #26, Individual #159, Individual #153, Individual #13), one received crisis intervention chemical restraint (Individual #26), and one received a physical escort (Individual #104). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for two of the five (Individual #104, Individual #159). The other individuals reviewed by the behavioral health Monitoring Team had no occurrences of crisis intervention restraint and were scored positively for this indicator. The Monitoring Team acknowledges that although Individual #13's trend was not decreasing over this nine-month period, the frequency of his restraints remained much lower than the high point that was occurring in the months leading up to and including December 2015. Further, he was more engaged in activities when observed by the Monitoring Team than he had been on previous onsite reviews.

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: Indicator 9 looks at a number of variables that should be in place to reduce the likelihood of behaviors that lead to restraint. Criteria were not met for the sub-indicators related to proper implementation of PBSP strategies. Indicator 10 will remain in the category of less oversight, however, proper protocols were not followed for consultation with behavioral health services prior to use of crisis intervention chemical restraint. In order for this indicator to remain in this category, this needs to be corrected for the next review. ISP IRRF sections now correctly documented restraint contra-indications, an improvement from previous reviews. These two indicators (9, 11), will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	104	26	159	153	13				
3	There was no evidence of prone restraint used.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
4	The restraint was a method approved in facility policy.										
5	The individual posed an immediate and serious risk of harm to him/herself or others.										
6	If yes to the indicator above, the restraint was terminated when the individual was no longer a danger to himself or others.										
7	There was no injury to the individual as a result of implementation of the restraint.										
8	There was no evidence that the restraint was used for punishment or for the convenience of staff.										
9	There was no evidence that the restraint was used in the absence of, or as an alternative to, treatment.	0% 0/5	Not rated	0/2	Not rated	0/2	0/1				
10	Restraint was used only after a graduated range of less restrictive	Due to the Center's sustained performance, this indicator was moved to the									

	measures had been exhausted or considered in a clinically justifiable manner.	category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	80% 4/5	1/1	1/1	1/1	1/1	0/1				

Comments:
The Monitoring Team chose to review seven restraint incidents that occurred for five different individuals (Individual #104, Individual #26, Individual #159, Individual #153, Individual #13). Of these, five were crisis intervention physical restraints, one was a crisis intervention chemical restraint, and one was a physical escort. 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 two of the individuals, this indicator was not scored for them. For this indicator, the Monitoring Team looks at eight different sub-indicators. For these three individuals, the Monitoring Team did not find that PBSP strategies were being routinely and correctly implemented, which if so, would have reduced the likelihood of restraint.

10. Behavioral health services consultation prior to implementation of crisis intervention chemical restraint for Individual #26 did not occur and was not documented properly.

11. Improvement was seen. The IRRFs for all, but one (Individual #13), individuals contained the proper information regarding restraint contraindication.

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.											
Summary: Staff who worked with all five individuals were interviewed and correctly answered the Monitoring Team's questions. 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	104	26	159	153	13				
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 5/5	1/1	1/1	1/1	1/1	1/1				

Comments:

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.	
Summary: Performance remained high, with one exception. With sustained high performance, this indicator might be moved to the category of requiring less	Individuals:

oversight after the next review.											
#	Indicator	Overall Score	104	26	159	153	13				
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	86% 6/7	1/1	1/2	1/1	2/2	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	N/A				
Comments: 13. For Individual #26 11/16/17, the restraint monitor arrived, but late, at 49 minutes, however, there was some conflicting data in the documentation as to the time of the initiation of the restraint. The Center was not able to clarify this discrepancy.											

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: monitoring individuals for potential side effects of chemical restraints; providing follow-up for abnormal vital signs, as well as injuries; 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	104	26	159	153	13				
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	20% 1/5	0/1	0/1	1/1	0/1	0/1				
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/5	0/1	0/1	0/1	0/1	0/1				
Comments: The crisis intervention restraints reviewed included those for: Individual #104 on 7/28/17 at 1:21 p.m., Individual #26 on 11/16/17 at 8:06 a.m. (chemical), Individual #159 on 8/17/17 at 5:48 p.m., Individual #153 on 11/8/17 at 4:54 p.m., and Individual #13 on 11/16/17 at 12:52 p.m. a. For all five crisis intervention restraints reviewed, nursing staff initiated monitoring at least every 30 minutes from the initiation of the restraint, which was good to see.											

For Individual #153's restraint on 11/8/17, nursing staff monitored and documented vital signs.

The following provide examples of concerns:

- For Individual #104, an escort was initiated due to his refusal to shower for several days, and the risk of infections and skin breakdown. Nursing staff did not document vital signs in IView and/or write an IPN.
- For Individual #26's chemical restraint on 11/16/17, neither the nursing IPN nor the Medication Administration Record (MAR) identified the site of the injection. A nursing IPN, dated 11/16/17 at 10:12 a.m., noted that he refused a body check and vital signs, but no additional IPNs were found showing attempts at re-checking him for injuries or taking his vital signs. In addition, an individual's cooperation is not needed to obtain respirations. On 11/16/17 at 1:05 p.m., IView entries for vital signs did not show follow-up for high or low vital signs. The Clinical Review of the restraint correctly identified risks related to the administration of Thorazine, such as hypotension, dizziness, central nervous system depression (e.g., sedation), and anticholinergic effects. However, the nursing assessments following the administration of the drug did not address these issues.
- Conflicting information was found in the documentation for Individual #153's restraint on 11/8/17. The Restraint Checklist indicated that the restraint occurred at 4:51 p.m., and the nurse was notified at 5:15 p.m., but the nurse documented in an IPN at 5:26 p.m. that the individual was assessed at 4:21 p.m.
- No nursing IPN was submitted for Individual #13's restraint on 11/16/17. The IView documentation showed vital signs that were high and/or low without necessary follow-up.

b. and c. As described in the examples above, no documentation was provided or documentation was incomplete for four of the restraint episodes.

The nurse documented Individual #159's injuries and contacted the physician, who provided new orders. Unfortunately, nursing staff did not document follow-up assessments for Individual #159.

For Individual #153, the nurse's IPN, dated 11/8/17, indicated that he agreed to a full body check and vital signs, but it did not describe a full head-to-toe assessment. Although a reference was made to seven injuries, nursing IPNs were not found to show ongoing nursing assessment of the injuries.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.	
Summary: Restraint documentation was, for the most part, good regarding those aspects monitored in this outcome and indicator. Some improvement is needed, and would be helpful to the reader, in the descriptive data in the IRIS restraint forms. For the Monitoring Team, determining what happened often took additional discussion with the Center staff. This is important because other SSLC and State Office staff will be reviewing/checking restraint documentation at El Paso SSLC from time to time. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	104	26	159	153	13				
15	Restraint was documented in compliance with Appendix A.	86% 6/7	1/1	1/2	1/1	2/2	1/1				

Comments:
15. For Individual #26 11/16/17, the documentation had two different restraint initiation times.

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

Summary: Some additional rigor should be applied to restraint reviews (indicator 16). Recommendations, when made, were implemented. This was an improvement from previous reviews. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	104	26	159	153	13				
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	71% 5/7	0/1	1/2	1/1	2/2	1/1				
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 2/2	1/1	N/A	N/A	N/A	1/1				

Comments:
16. For Individual #104 7/28/17, the review did not detect any potential policy question on the use of modified restraint, that is, there was no review of the special circumstances associated with this escort procedure. For Individual #26 11/16/17, the review did not detect conflict data regarding initiation times.

17. Many of the individuals had crisis intervention plans.

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

Summary: Crisis intervention chemical restraint rarely occurred at El Paso SSLC. When it did occur, multiple medications were not used. This has been the case for some time. Therefore, indicator 48 will be moved to the category of requiring less oversight. The other two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	26								
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	100% 1/1	1/1								
48	Multiple medications were not used during chemical restraint.	100% 1/1	1/1								

49	Psychiatry follow-up occurred following chemical restraint.	0% 0/1	0/1								

Comments:
47-48. These indicators applied to a chemical restraint for Individual #26. The review form was completed within the required timeframe.

49. There was no documentation of psychiatric follow-up after 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 continued to regularly review trends and supports/plans were in place to have reduced the likelihood of the incidents occurring. All four sub-indicators met criteria. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 179	63	9	192	104	26	159	153	
1	Supports were in place, prior to the allegation/incident, to reduce risk of abuse, neglect, exploitation, and serious injury.	100% 12/12	1/1	2/2	1/1	2/2	1/1	1/1	1/1	3/3	

Comments:
The Monitoring Team reviewed 12 investigations that occurred for eight individuals. Of these 12 investigations, seven were DFPS investigations of abuse-neglect allegations (one confirmed, four unconfirmed, one inconclusive, and one administrative referral). The other five were for facility investigations of a serious injury (fracture), a sexual incident, an unauthorized departure, contact with law enforcement, 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 #179, UIR 17-205, DFPS 45322800, inconclusive allegation of abuse, 6/10/17
- Individual #63, UIR 17-190, discovered injury, rib fracture, 5/19/17
  - This injury incident was also investigated by DFPS (inconclusive) and OIG (no findings of criminal activity).
- Individual #63, UIR 17-174, sexual incident, 5/4/17
- Individual #9, UIR 18-022, DFPS 45770348, unconfirmed allegations of physical abuse and neglect, 11/5/17
- Individual #192, UIR 18-027, DFPS 45775169, unconfirmed allegation of physical abuse, 11/6/17
- Individual #192, UIR 18-023, suicide threat, 11/5/17
- Individual #104, UIR 17-279, DFPS 45444141, confirmed allegation of physical abuse-2, 8/27/17
- Individual #26, UIR 17-297, DFPS 45552772, unconfirmed allegation of abuse, 9/19/17
- Individual #159, UIR 17-268, unauthorized departure, 8/7/17
- Individual #153, UIR 17-287, DFPS 45489768, unconfirmed allegation of abuse, 9/6/17

- Individual #153, UIR 18-003, DFPS 45561806, administrative referral of an allegation, 9/25/17
- Individual #153, UIR 17-280, law enforcement encounter, 8/29/17

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

All aspects (sub-indicators a, b, c, and d) met criteria for those investigations for which those indicators were applicable. That is, sufficient background and duty to report activities were completed, and the behaviors that occurred during the incidents were ones that had occurred before, and there was prior review, trending, supports/plans in place (typically a PBSP), and review of those supports/plans.

There were no individuals designated by DFPS for streamlined investigations. There were no streamlined investigations. There were no investigations that found the allegations to be unfounded. One individual (Individual #153) was on the Center's list of chronic callers, however, none of the special arrangements allowed for in policy were ever implemented. In other words, full investigations were conducted for every allegation and incident. The Center's policy on chronic callers was from 2014 and should be updated.

Outcome 2- Allegations of abuse and neglect, injuries, and other incidents are reported appropriately.

Summary: All incidents were reported properly, with one exception. This was for an incident in which the reporter was unknown, but there was no attempt by the investigation to determine if the caller was the individual, staff, or someone else. Digging deeper to make this determination should become typical for these types of allegations. Even so, given a high level of performance and absence of any egregious problems over this and the last four consecutive reviews, this indicator will be moved to the category of requiring less oversight.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	159	153	
2	Allegations of abuse, neglect, and/or exploitation, and/or other incidents were reported to the appropriate party as required by DADS/facility policy.	92% 11/12	1/1	2/2	1/1	2/2	0/1	1/1	1/1	3/3	

Comments:

2. The Monitoring Team rated 11 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 #104, 17-279: Per DFPS, the incident occurred on 8/26/17 and was reported on 8/27/17. Per the UIR, the reporter was unknown. The UIR, however, did not report any effort to identify the reporter, that is, whether the reporter was likely the

individual, a staff member, or someone else. Without any effort to put forward a hypothesis regarding the report, the Monitoring Team cannot confirm when the incident was first detected and, therefore, should have been reported at that time.

- Digging deeper to make this determination should become typical for these types of allegations.

When there are apparent inconsistencies in date/time of events in a UIR, the UIR itself should explain them, and/or the UIR Review/Approval form should identify the apparent discrepancies and explain them.

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:			Individuals:										
#	Indicator	Overall Score											
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:													

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 utilized.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
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:												

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: There was no improvement in performance for indicator 15. It will remain in active monitoring.	Individuals:

#	Indicator	Overall Score									
			179	63	9	192	104	26	159	153	
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, this indicator was moved to the category of requiring less oversight.									
15	For this individual, non-serious injury investigations provided enough information to determine if an abuse/neglect allegation should have been reported.	38% 3/8	0/1	0/1	0/1	0/1	1/1	1/1	1/1	0/1	

Comments:
15. Three individuals did not have non-serious injuries that warranted a non-serious injury audit. The other five individuals had one or more non-serious injuries that should have resulted in a non-serious injury investigation, but didn't. This was the same as at the last review. The Center would benefit from some guidance from State Office.

Outcome 9– Appropriate recommendations are made and measurable action plans are developed, implemented, and reviewed to address all recommendations.

Summary: See comments below regarding indicator 17 and confirmations of physical abuse category 2.	Individuals:

#	Indicator	Overall Score									
16	The investigation included recommendations for corrective action that were directly related to findings and addressed any concerns noted in the case.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
17	If the investigation recommended disciplinary actions or other employee related actions, they occurred and they were taken timely.										
18	If the investigation recommended programmatic and other actions, they occurred and they occurred timely.										

Comments:
17. There were four cases in which an alleged perpetrator was confirmed for physical abuse category 2. In three of these cases, employment was discontinued. In one case, employment was continued, but the SSLC protocols were not followed.

Outcome 10– The facility had a system for tracking and trending of abuse, neglect, exploitation, and injuries.

Summary: This outcome consists of facility indicators. Various data were collected regarding allegations, findings, injuries, and unusual incidents. A format existed for presentation of the data. This was good to see, however, more work was needed in the depth of the analysis. The Monitoring Team recommends that the IMC obtain assistance from the State Office discipline coordinator. 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.	No									
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. The analysis of trends needs some improvement. The QAQI report contained relevant sub-sections for each data set presented: identify trend, explain the trend, what actions will be taken, and future predictions. The analysis should also include a more longitudinal view of the data, and consideration of various other factors that impact abuse/neglect, and unusual incidents.											

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	0% 0/2	0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If individual is administered oral pre-treatment sedation for dental treatment, proper procedures are followed.	N/A									
Comments: a. The Center had a policy, dated 9/8/15 and revised on 11/1/17, entitled Total Intravenous Anesthesia. The Center currently utilized full general anesthesia with endotracheal intubation. The policy provided some basic exclusion criteria, such as age greater than 60, presence of respiratory issues, use of gastrostomy tube (G-tube), etc. The policy also required that physicians conduct a preoperative evaluation, but it did not include some basic disease-specific guidelines (e.g., the requirement to obtain cervical spine films for individuals with Downs, etc.). All individuals scheduled to undergo non-cardiac surgery should have an assessment of perioperative risk. The clinician should use information obtained from the history, physical examination, and the type of surgery in										

order to develop an initial estimate of perioperative cardiac risk. There are a number of risk tools available, such as the revised cardiac risk index (RCRI). Until the Center is implementing improved policies, it cannot make assurances that it is following proper procedures. Given the risks involved with general anesthesia, it is essential that such policies be developed and implemented.

For these two instances of the use of general anesthesia, informed consent for the general anesthesia was present. Nothing-by-mouth status was confirmed for Individual #104, but not Individual #192. The operative notes submitted did not define the procedures and assessments completed, and due to incomplete information for Individual #192, the time at which post-operative vital signs should have commenced could not be determined.

b. None of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	0% 0/2	N/A	0/2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. Informed consent was not provided for the pre-treatment medical sedations of Individual #104 on 11/3/17 (i.e., emergency use for a CT scan) or 11/8/17 (i.e., for transport to the hospital). No pre- or post-procedure vital signs were documented.											

Outcome 1 - Individuals' need for pretreatment sedation (PTS) is assessed and treatments or strategies are provided to minimize or eliminate the need for PTS.											
Summary: Monitoring of this outcome and its indicators is put on hold while the State develops instructions, guidelines, and protocols for meeting criteria with this outcome and its indicators.			Individuals:								
#	Indicator	Overall Score									
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.										
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.										
3	If treatments or strategies were developed to minimize or eliminate										

	the need for PTS, they were (a) based upon the underlying hypothesized cause of the reasons for the need for PTS, (b) in the ISP (or ISPA) as action plans, and (c) written in SAP, SO, or IHCP format.										
4	Action plans were implemented.										
5	If implemented, progress was monitored.										
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.										
Comments:											

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	71	113	189	10					
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.	75% 3/4	1/1	1/1	1/1	0/1					
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	0% 0/4	0/1	0/1	0/1	0/1					
e.	Recommendations are followed through to closure.	0% 0/4	0/1	0/1	0/1	0/1					

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

- On 4/9/17, Individual #71 died at the age of 63 with causes of death listed as sepsis, infected abdominal wound, and spina bifida;
- On 4/25/17, Individual #113 died at the age of 59 with causes of death listed as prolonged immobilization, chronic aspiration,

aspiration pneumonia, and septic shock;

- On 6/11/17, Individual #189 died at the age of 43 with causes of death listed as intracranial hemorrhage, and possible ruptured aneurysm;
- On 8/21/17, Individual #10 died at the age of 70 with causes of death listed as anoxic encephalopathy, cardiac arrest, and gastrointestinal hemorrhage. The Administrative Death Review did not occur within 14 days of the Clinical Death Review; and
- Based on information gained on site, Individual #90 died on 12/26/17, at the age of 67. Based on information the State provided after the onsite review, Individual #90 died after he was transferred to a hospice facility.

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

e. It did not appear that the Center's tracking log tracked all recommendations emanating from the clinical and administrative death reviews. In addition, the recommendations generally were not written in a way that ensured that Center practice had improved. For example, a recommendation that read: "Medical clinic their [sic] protocol for on call in the event that the staff cannot get a hold of the provider" resulted in a change to a policy. This in no way ensured that concerning practices changed. The recommendation should have been written in a manner that required monitoring to determine whether or not the medical on-call system was working efficiently, and that staff had access to medical consultation when needed.

Quality Assurance

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: For the one ADR identified, Center staff took the necessary actions.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
b.	Clinical follow-up action is completed, as necessary, with the individual.	100% 1/1									1/1
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	100% 1/1									1/1
d.	Reportable ADRs are sent to MedWatch.	N/A									N/A
Comments: a. through d. It was good to see the Center staff reported Individual #102's metabolic acidosis secondary to Topirimate, took necessary clinical action, and on 11/15/17, discussed it thoroughly in the Pharmacy and Therapeutics Committee meeting. Two additional potential ADRs had been reported for individuals reviewed. However, the process for reviewing them was not complete											

at the time of the document cut-off date. Therefore, the Monitoring Team did not review them.

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: Due to the fact that since the last review, timely quarterly DUEs were not completed, Indicators a and b will return to active oversight.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	Due to the Center's sustained performance with these indicators, at the time of the last review, they moved to the category requiring less oversight. However, based on a decrease in performance, they will return to active oversight.
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	
Comments: a. and b. Based on documentation submitted, two DUEs were completed: one in March 2017, and one in August 2017. The one in August was overdue, and another one should have been completed in approximately November 2017. As a result, these two indicators will return to active oversight. In its response to the draft report, the State disputed this finding and argued that because the Center followed its DUE calendar that called for the completion of DUEs in February, March, August, and December, it met the requirements. The Center's calendar for DUEs in no way met the quarterly requirement that is clearly articulated in Indicator 4.a. The Monitoring Team's original finding stands.		

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 were moved to, or were already in, the category of requiring less oversight. For this review, three other indicators were moved to this category, in ISPs and psychiatry. Five indicators in communication, nursing, and skill acquisition plans, 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.

The Monitoring Team observed many positive interactions among staff and individuals. For the most part, staff knew the individuals well and were familiar with many of their preferences and needs.

Assessments

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

None of the IDTs arranged for and obtained all needed, relevant assessments as identified by the IDT prior to the ISP meeting.

Some concerns were noted with regard to the timeliness of medical assessments. If such issues persist at the time of the next review, the related indicator might return to active oversight.

Center staff should continue to improve the quality of the medical assessments with particular focus on the plan of care section.

It was positive that the Dental Department completed annual dental summaries in a timely manner. The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams and 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.

The Center needs to do a better job of assessing individuals for possible work skills and developing goals that might lead to meaningful employment, particularly for younger individuals who have never had the opportunity to work or who have had very limited work experiences.

Psychiatric assessments were timely and provided to the ISP within the required time limits. The psychiatry clinic had adjusted their schedule in order to ensure that the annual CPE was performed in conjunction with the ISP meeting. Some items were missing from many of the CPEs. This may be, at least in part, a function of the CPEs being a few years old and, therefore, requiring some updating to meet criteria.

Not all behavioral health assessments or functional assessments were current and complete. FSAs were not being conducted for any individuals.

With regard to the PNMT, the PNMT Nurse position was vacant, which resulted in a lack of post-hospitalization reviews. Problems also were noted with regard to timely referral of individuals to the PNMT, timely completion of the PNMT initial review, and completion of PNMT comprehensive assessments for individuals needing them.

Center staff had not followed the current guidelines for considering when an OT/PT comprehensive should be repeated. For a number of individuals reviewed, the three-year mark had passed, and OTs/PTs had not completed a new comprehensive assessment, or justified why an update met the individual's needs. The OT/PT updates reviewed generally met criteria, which was good to see. The comprehensive assessment reviewed needed improvement.

Individualized Support Plans

El Paso SSLC ISPs continued to have many goals that were individualized (though somewhat less than at the last review) and many of these goals were written in measurable terms. None, however, were implemented sufficiently or with adequate collection of data for there to be progress and/or a determination of progress. QIDP monthly reviews indicated that a majority of goals were either never implemented or not consistently implemented. This is a repeat finding from the last review.

Action plans, for the most part, did not provide a path to accomplishment of the individuals' personal goals. IDTs need further guidance on developing action plans/staff instructions that might lead to progress or achievement of goals.

For the most part, IDTs did not address the previous year's barriers to implementation or to progress.

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.

Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines.

IDTs met routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented.

The El Paso SSLC psychiatry department made good progress in developing/creating psychiatry-related goals. It is likely, that with some additional attention to the specific criteria, these indicators will move further towards meeting criteria at the next review. Note that indicator 6 was scored at 78%. Two areas for focus are ensuring the psychiatric indicators are well defined and measurable (indicator 5); and ensuring that reliable and valid data are being collected for the psychiatric indicators (indicator 7). These indicators will remain in active monitoring.

Psychiatry documentation for the ISP was submitted on time for all individuals. A next step is to get the relevant information into the IRRF section of the ISP to address indicator 21. Psychiatric Support Plans (PSPs) were used for 10 individuals at El Paso SSLC. Given the Monitoring Team's findings, they should all receive review, attention, and updating.

In behavioral health, target and replacement data were found to be reliable for less than half of the individuals (though this was an improvement from the last reviews). Most PBSPs were current, but none contained all of the required/expected content.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.											
Summary: El Paso SSLC ISPs continued to have many goals that were individualized (though somewhat less than at the last review) and many of these goals were written in measurable terms. None, however, were implemented sufficiently or with adequate collection of data for there to be progress and determination of progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	63	192	104	159	103	90			
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	4/6	4/6	2/6	4/6	3/6	1/6			

2	The personal goals are measurable.	0% 0/6	3/6	3/6	1/6	1/6	2/6	1/6			
3	There are reliable and valid data to determine if the individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: (Individual #104, Individual #192, Individual #159, Individual #63, Individual #90, Individual #103). 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. The ISP relies on the development of personal goals as a foundation. Personal goals should be aspirational statements of outcomes. The IDT should consider personal goals that promote success and accomplishment, being part of and valued by the community, maintaining good health, and choosing where and with whom to live. The personal goals should be based on an expectation that the individual will learn new skills and have opportunities to try new things. Some personal goals may be readily achievable within the coming year, while some will take two to three years to accomplish. Personal goals must be measurable in that they provide a clear indicator, or indicators, that can be used to demonstrate/verify achievement. The action plans should clearly support attainment of these goals and need to be measurable. The action plans must also contain baseline measures, specific learning objectives, and measurement methodology.

None of the six individuals had individualized goals in all areas. Therefore, none had a comprehensive set of goals that met criterion. For these all individuals, however, the IDT had defined/chosen some personal goals that met criterion for being individualized, based on the individual's preferences and strengths. Overall, 18 of 36 personal goals met criterion for this indicator, this was a decrease from 23 at the last review. Goals that met criterion were:

- Individual #104's goals for relationships and living options.
- Individual #192's goals for recreation/leisure, work/day, greater independence, and living options.
- Individual #159's goals for recreation/leisure, relationships, greater independence, and living options.
- Individual #63's goals for recreation/leisure, relationships, greater independence, and living options.
- Individual #90's goals for relationships, greater independence, and living options.
- Individual #103's living option goals.

Although IDTs had created the above goals (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.

2. Of the 18 personal goals that met criterion for indicator 1, 11 also met criterion for measurability. The goals that also met this criterion were:

- Individual #104's living options goal.
- Individual #192's goals for recreation/leisure, work/day, and living options.

- Individual #159's living options goal.
- Individual #63's goals for recreation/leisure, greater independence, and living options.
- Individual #90's goals for greater independence and living options.
- Individual #103's living option goals.

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.

3. None of the goals had reliable and valid data to determine if the individual met, or was making progress towards achieving, his or her overall personal goals. As noted throughout this report, for all of the other goals, it was not possible to determine if ISP supports and services were being regularly implemented or to determine the status of goals because of the lack of data and documentation provided by the facility. While there were some data collected showing implementation of some action plans, there was not enough information documented to clearly determine the status of goals. Furthermore, it appeared that no action plans were consistently implemented.

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

Summary: Performance was about the same as last time. More specifically, each of these 11 indicators scored the same or less than last time. The Monitoring Team suggests that ISPs be subjected to a quality review for these 11 indicators, which look at the overall set of ISP action plans. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 63	192	104	159	103	90			
8	ISP action plans support the individual's personal goals.	0% 0/6	2/6	2/6	0/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
10	ISP action plans addressed identified strengths, needs, and barriers related to informed decision-making.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
11	ISP action plans supported the individual's overall enhanced independence.	50% 3/6	1/1	1/1	0/1	0/1	0/1	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	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

	adaptive needs.										
14	ISP action plans integrated encouragement of community participation and integration.	33% 2/6	0/1	1/1	0/1	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	1/1	0/1	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
18	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

8. Eighteen of the personal goals met criterion in the ISPs, as described above in indicator 1, therefore, those action plans could 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.

Action plans, for the most part, did not support accomplishment of the individuals' personal goals. Many skill acquisition programs were never developed and for the ones that were, they did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Service objectives did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress. IDTs need further guidance on developing action plans/ staff instructions that might lead to progress or achievement of goals.

For the 18 personal goals that met criterion under indicator 1, four had action plans that were likely to lead to the accomplishment of the goal. IDTs were struggling with developing action steps that would lead to measurable progress towards goals. Goals that met criterion were:

- Action plans for Individual #192's recreation/leisure and greater independence goal.
- Action plans for Individual #63's greater independence and living option goals.

9. Individual #192 and Individual #63 had action plans that integrated preferences and opportunities for choice. IDTs for four individuals either failed to adequately identify their preferences through the assessment process or did not develop opportunities for choice throughout their day.

10. None of these six ISPs clearly addressed strengths, needs, and barriers related to informed decision-making.

11. Three of six ISPs met criterion for this indicator to support the individual's overall independence.

- Individual #63's ISP included action plans for washing his clothes, washing his hands, and increasing his communication skills.

- Individual #90's action plans (minimally) supported greater independence through a walking SAP.
- Individual #192's ISP included action plans to use public transportation and sell his jewelry. Both would increase his independence, however, neither had been implemented.

12. Five of six ISPs did not integrate strategies to minimize risks in ISP action plans. As noted above, IDTs failed to develop specific teaching and support strategies to carry out action plans, thus, they did not have an avenue to integrate support strategies to address risks into action plans. Individual #159's ISP did integrate strategies to reduce his risk for weight gain in action plans to achieve his recreation and relationship goals. Specific support strategies should be included in staff instruction for implementing action plans, when relevant, to minimize risks in all settings.

- For example, Individual #104's action plans did not integrate strategies to minimize his risks for pica and weight gain.
- Individual #192's pica diagnosis was not addressed in his PBSP.
- Strategies to reduce Individual #63's risk for falls were not integrated into his action plans. Nor were assessment findings that noted his self-injurious behaviors increased when he was over prompted.
- Physical therapy strategies to reduce Individual #90's risk for falls were not integrated into his walking plan.

Further discussion regarding the quality of strategies to reduce risks can be found throughout this report.

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 most cases, supports were fragmented, with little evidence that IDT members were sharing data and collaborating on developing supports. Examples where discipline assessments and recommendations were not fully integrated included:

- Individual #159's ISP did not integrate his IEP goals. There was little discussion regarding his school programming and supports that could be provided at the facility to support success in school.
- Individual #63's had a communication action plan. Communication strategies were not integrated into other action plans.
- Individual #192's physical therapy recommendations were not integrated into his action plans to use public transportation or in his work-related action plans. Plans to assess and address his risk for falls was somewhat fragmented among disciplines. For example, medications thought to contribute to his risk for falls were discontinued, however, his physical therapist did not reassess him following the change in medication to assess the impact on his gait. The team needs to work together to continue to assess the efficacy of supports and ensure that his risk for falling is adequately addressed.
- Individual #104's communication plan was not fully discussed by the team, integrated into his ISP, or implemented. His diet plan appeared not to be integrated into his behavioral strategies, which used food as a reward for positive behavior. The IDT had not taken an integrated approach to address his frequent refusals to complete hygiene tasks or attend programming. The IDT did, however, begin to consider a more integrated approach to developing supports at his ISP Preparation meeting during the onsite week.
- Individual #103's therapy recommendations were not integrated into other action plans.

14. Meaningful and substantial community integration was absent from four of six ISPs. Individual #159 was attending school in the community. Individual #192's goals to use public transportation and sell his jewelry in the community supported opportunities for community integration. These would have been great opportunities for meaningful engagement and integration in the community,

however, neither goal had been implemented. Although other individuals had opportunities to go into the community and outings were documented, none of the individuals had formalized training with adequate teaching strategies that might lead to integration into the community.

15. Four ISPs did not include action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. As noted above, Individual #159 and Individual #192 had goals for school and work in the community. Individual #104, Individual #63, Individual #90, and Individual #103's ISPs did not adequately define their preferences related to work and day programming.

Some of the other individuals, specifically those who were not previously engaged in meaningful activity throughout the day, were now working and seemed to really enjoy their jobs (e.g., Individual #13, Individual #153, Individual #26).

16. One ISP supported substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. This was Individual #159, who attended school in the community.

- Individual #104's IDT had not adequately assessed his preferences for day programming. He had a generic plan to attend the day program. He was 29 years old and had not been assessed for possible work interests and skills.
- Individual #192 was observed working at various jobs around the facility. He reported that he did not particularly like his job, but did enjoy working and getting paid. Direct support staff confirmed that he was a hard worker with many job skills. His IDT should update his vocational assessment and support him to explore work opportunities based on his preferences and skills.
- Individual #63 did not have a current functional skills or vocational assessment. It was not evident that his IDT had considered work opportunities or day programming that might expand his skills and lead towards more meaningful engagement during the day.
- Individual #90 and Individual #103's ISPs did not include a clear description of how they would spend much of their day. Individual #103 was not meaningfully engaged during onsite observations. Her work/day goal to play cup pong had never been implemented and was unlikely to lead to meaningful engagement for the major part of her day, if implemented.

The facility had expanded recreational opportunities to include new opportunities for day programming, however, none of the individuals were participating in the new programs. Hopefully, these new programs will be used to assess day and work skills and preferences and provide functional training for more individuals at the facility.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Individual #104's ISP preparation meeting was observed. The IDT reviewed his goals and noted that most of his action plans were never fully implemented. They did not address the previous year's barriers to implementation or to progress.

18. None of the action plans described detail about data collection and review. Overall, ISPs did not usually 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 most 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: All of the indicators showed performance that either remained the same or improved (except for indicator 28, which showed a decrease). Overall, this showed that some additional attention to community living was occurring at El Paso SSLC. For example, identification of individuals' preferences improved to 100%. Also, during ISP meetings observed by the Monitoring Team, individual's community living preferences were described and determined. This has been the case for this review and the previous two reviews, too. Therefore, indicator 20 will be moved to the category of requiring less oversight. With additional attention, as detailed in the comments below, performance is likely to improve further for these indicators. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	63	192	104	159	103	90			
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).	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A			
21	The ISP included the opinions and recommendation of the IDT's staff members.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	100% 6/6	1/1	1/1	1/1	1/1	1/1	1/1			
23	The determination was based on a thorough examination of living options.	67% 4/6	1/1	1/1	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).	83% 5/6	1/1	1/1	1/1	1/1	0/1	1/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	100% 1/1	N/A	N/A	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	1/1	0/1	0/1	1/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A			

	individual was currently referred, to transition.										
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	20% 1/5	1/1	0/1	0/1	N/A	0/1	0/1			
29	The IDT developed action plans to facilitate the referral if no significant obstacles were identified.	N/A	N/A	N/A	N/A	N/A	N/A	N/A			

Comments:

19. Living option goals were developed to support individual's preferences. This was an improvement from the previous review. IDTs, however, were still struggling to develop individualized action plans that were likely to lead to the accomplishment of those goals, thus, little progress had been made towards achieving living option goals.

20. The Monitoring Team observed the annual ISP meeting for Individual #152. Although he could not express his preference directly, the IDT noted that he loved being with his brother. His brother had moved to another state (one that adjoins Texas) and the IDT felt that Individual #152would like to be near his brother.

21. One ISP (Individual #159) fully included the opinions and recommendation of the IDT's staff members. For the other five individuals, assessments that included living option recommendations were not submitted prior to the ISP meeting for consideration.

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

23. Four of the individuals had a thorough examination of living options based upon their preferences, needs, and strengths. Individual #90 and Individual #103's ISPs did not document a thorough discussion.

24. Five of six ISPs identified a thorough and comprehensive list of obstacles to referral in a manner that should allow relevant and measurable goals to address the obstacle to be developed. Individual #103's ISP noted that her medical issues were a barrier to community placement, however, her annual medical assessment indicated that supports could be provided in the community and recommended that the team consider referral to the community. The IDT did not clearly define what medical supports could not be provided in the community.

25. For Individual #152, the IDT identified the sole obstacle to referral being learning about what was required to be referred to, and transition to, the other state's community service program.

26. Two of six individuals (Individual #159, Individual #63) had individualized, measurable action plans to address obstacles to referral. Examples included:

- For the most part, action plans to address individual awareness and LAR reluctance did not have individualized measurable action plans with learning objectives or outcomes.
- Individual #104's action plans to address behavioral-related obstacles to referral stated that "behavioral episodes will improve". This did not clearly define for the IDT what would have to occur for a referral to be considered.
- Individual #103's ISP did not include action plans for her living option goal.

27. For Individual #152, the transition specialist agreed to look into the requirements for the other state's program. No specific plans to address this, other than initial information gathering, were yet developed.

28. None of the ISPs had individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs.

29. None of the individuals were referred to the community.

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

Summary: Implementation of ISP action plans were delayed, or even more often, not done at all (indicator 32). This is one of the most critical aspects of service and support provision and should be a priority for the Center. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 63	192	104	159	103	90			
30	The ISP was revised at least annually.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
31	An ISP was developed within 30 days of admission if the individual was admitted in the past year.										
32	The ISP was implemented within 30 days of the meeting or sooner if indicated.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
33	The individual participated in the planning process and was knowledgeable of the personal goals, preferences, strengths, and needs articulated in the individualized ISP (as able).	83% 5/6	0/1	1/1	1/1	1/1	1/1	1/1			
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	17% 1/6	0/1	0/1	0/1	1/1	0/1	0/1			

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis. QIDP monthly reviews indicated that a majority of goals were either never implemented or not consistently implemented. This is a repeat finding from the last review.

33. Five individuals attended their ISP meetings. Individual #63's guardian requested that he not attend his meeting.

34. One individual (Individual #159) had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Overall, participation was good among individuals and their LARs. Individual #192's LAR was unable to attend his meeting.
- Individual #104's psychiatrist and SLP did not attend his meeting. He had significant needs in both behavior and

communication.

- Psychiatry staff did not submit an assessment prior to Individual #192's ISP meeting and did not attend the meeting.
- Individual #103's medical staff did not attend her meeting or submit her annual physical at least 10 days prior to the meeting for review by other team members.

Data presented at the Quarterly QAQI Council meeting indicated that attendance at ISP meetings since the last onsite review (April 2017) fluctuated monthly between 79% and 88%.

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

Summary: Both indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 63	192	104	159	103	90			
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.	60% 3/5	1/1	N/A	0/1	1/1	0/1	1/1			
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 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 three of five individuals. Individual #192 was recently admitted, thus, he did not have an ISP preparation meeting where that discussion would be documented.
    - Individual #104's IDT did not identify his need for a comprehensive day/vocational assessment to determine his interests and skills that might relate to employment or a meaningful day program.
    - Individual #103's IDT did not recommend a hearing evaluation, although her ISP noted that her hearing level was unknown. She had not had a hearing exam since 2013.

36. None of the IDTs arranged for and obtained all needed, relevant assessments as identified by the IDT prior to the ISP meeting.
    - Individual #104's FSA and annual medical assessment were not submitted at least 10 days prior to his ISP meeting according to QIDP data.
    - Individual #192's behavioral assessment, functional skills assessment, and psychiatric assessment were not submitted timely.
    - Individual #159's annual medical exam was submitted late and his functional skills assessment had not been updated prior to his ISP meeting.
    - Individual #63's behavioral and vocational assessments were not submitted prior to his ISP meeting.
    - Individual #90's nursing, behavioral, functional skills, annual medical, and comprehensive psychiatry assessments were not timely per QIDP data.
    - Individual #103's behavioral and recreational assessments were not timely.

The facility needs to develop a plan to ensure that assessments are available to IDT members at least 10 days prior to the ISP meeting

for review. Without assessment information available to the team, it is unlikely that all supports will be developed to address preferences, needs, and risks at the annual ISP meeting.

Data reviewed for the last quarter at the QAQI Council meeting indicated that some disciplines were frequently not submitting assessments on time. The following table represents timely submission of assessments by discipline for the quarter reviewed:

Discipline	% Submitted timely
Behavioral Services	40%
Medical	75%
Dental	100%
Habilitation Therapy	100%
Communication	100%
Nursing	75%
Pharmacy	100%
Program Development	67%
Psychiatry	0%
Vocational	100%

Outcome 7: Individuals' progress is reviewed and supports and services are revised as needed.

Summary: The need for conduct of monthly reviews remained evident. The Center might consider developing some sort of step-wise plan to move towards better compliance with the requirements of these indicators. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	63	192	104	159	103	90			
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 routinely when a serious incident occurred. This was good to see, however, when recommendations were made or supports were revised, IDTs rarely met again to ensure that recommendations were implemented. Furthermore, reliable and valid data were often not available to guide decision-making.

IDTs rarely revised goals when progress was not evident. ISPs were not fully implemented for any individual. IDTs sometimes discontinued goals that were not being implemented, however, did not meet to revise goals or address barriers to prior

implementation.

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. Monthly reviews were often late or not completed in a timely manner. For example, Individual #103's June 2017 and July 2017 monthly reviews were completed on 9/6/17. Individual #90's last monthly review submitted to the Monitoring Team was for June 2017. No monthly reviews were completed June 2017 through October 2017 for Individual #63.

Some QIDP monthly reviews included data for some action plans, but did not include an analysis of those data to determine what specific progress had been made towards achievement of goals. Information regarding behavioral supports, habilitation therapy, and medical supports was inserted in the monthly reviews without a summary of status, statement on the efficacy of supports, or efforts made to follow-up on outstanding issues. There was little documentation of follow-up when plans were not implemented or not effective.

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility response to incidents. At all meetings, reliable data were not available for review to facilitate decision making and ensure that supports were revised when not effective.

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, particularly when goals are not consistently implemented.

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

Summary: In order to assign accurate risk ratings, IDTs need to improve the quality and breadth of clinical information they gather as well as improve their analysis of this information. Teams also need to ensure that when individuals experience changes of status, they review the relevant risk ratings within no more than five days. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
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.	44% 8/18	0/2	2/2	0/2	1/2	2/2	1/2	1/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 risk areas [i.e., Individual #192 – falls, and other: pica; Individual #104 – circulatory, and dental; Individual #90 – aspiration, and gastrointestinal (GI) problems; Individual #103 – respiratory compromise, and skin integrity; Individual #82 – cardiac disease, and constipation/bowel obstruction; Individual #99 – diabetes, and GI problems; Individual #4 – weight, and constipation/bowel obstruction; Individual #25 – infections, and seizures; and Individual #102 – skin integrity, and urinary tract infections (UTIs)].

a. Overall, IDTs did not effectively use supporting clinical data, and as appropriate, provide clinical justification for exceptions to the guidelines. Often, it appeared that IDTs did use the risk guidelines.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs completed IRRFs for individuals within 30 days of admission and updated the IRRFs at least annually. However, it was concerning that when changes of status occurred that necessitated at least review of the risk ratings, IDTs often did not review the IRRFs, and make changes, as appropriate. The following individuals did not have changes of status in the specified risk areas: Individual #104 – circulatory, and dental; Individual #103 – skin integrity; Individual #82 – cardiac disease, and constipation/bowel obstruction; Individual #99 – diabetes; Individual #4 – weight; and Individual #25 – seizures.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.

Summary: El Paso SSLC made good progress towards meeting criteria with the indicators of this outcome. It is likely, that with some additional attention to the specific criteria, that these indicators will meet the criteria for these indicators at the next review. Note that indicator 6 was scored at 78%. The El Paso SSLC psychiatrist continued to be responsive to feedback from the Monitoring Team, as reflected in the improved performance related to goal development and psychiatric indicator identification. Two areas for focus are ensuring the psychiatric indicators are well defined and measurable (indicator 5); and ensuring that reliable and valid data are being collected for the psychiatric indicators (indicator 7). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
4	The individual has goals/objectives related to psychiatric status.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
5	The psychiatric goals/objectives are measurable.	0% 0/8	0/1	N/A	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.	88% 7/8	1/1	N/A	1/1	1/1	0/1	1/1	1/1	1/1	1/1
7	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
The El Paso SSLC psychiatry department continued to make good progress in developing psychiatry-related goals for individuals. This outcome contains four indicators that each get at an important aspect of the goals. Each will be discussed in turn below.

A number of years ago, the State proposed terminology to help avoid confusion between psychiatry treatment and behavioral health services treatment, though the two disciplines must work together in order for individuals to receive comprehensive and integrated clinical services, and to increase the likelihood of improvement in psychiatric condition and behavioral functioning.

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

In psychiatry, the focus is upon what have come to be called psychiatric indicators. These are the observable, measurable symptoms chosen by the psychiatrist (with input from behavioral health services and IDT members) to determine the presence, level, and severity of the individual's psychiatric disorder. They are hypothesized to be, for the most part, due to the individual's psychiatric disorder. Psychiatric indicators can be psychometrically sound rating scales, and/or data collection recordings of symptoms directly observed by SSLC staff. Psychiatric indicators need to be directly related (derived from) the individual's diagnosis or diagnoses. Individuals should have psychiatric indicators (and goals) that are related to the reduction of psychiatric symptoms and goals/objectives related to the increase of positive/desirable behaviors.

Goals for behavioral health services typically appear in the functional assessment and/or the PBSP. Goals for psychiatry typically appear in the annual psychiatry update and/or quarterly psychiatry clinic review reports. Goals for behavioral health services and for psychiatry ultimately need to appear in the behavioral health risk section of the IHCP.

4. The Monitoring Team looks at the set of goals for each individual. Goals must include the focus of the goal (i.e., psychiatric indicators), address the reduction of symptoms and the increase of prosocial behaviors, and include criterion.

At El Paso SSLC, goals for none of the individuals met all of the criteria, however, there was excellent progress as described in some detail below, along with specific feedback and suggestions from the Monitoring Team.

- All individuals had one or more goals for reduction of symptoms and one or more goals for prosocial behaviors.
- Overall, goals had a desired number of occurrences (e.g., two or less episodes per month, 80% of opportunities per month), and a length of time (e.g., six consecutive months). This was good to see. The goals also need to have a desired end time (e.g., by December 31, 2018). None of them had this latter item.
- Many goals showed good progress towards operational definitions of the psychiatric indicators. For example, rather than solely writing "depression," the indicator defined depression for the individual (e.g., "relates to his feelings, crying, anhedonia, sleep disturbances and weight loss which is directly correlates to when his mother does not visit him"). This, however, was not the case for all psychiatric indicators.
- Goals need to appear in the IHCP section of the ISP.

5. Goals must be measurable. That is, the psychiatric indicators in each goal must be observable and measurable. They must be designed so that their reliability can be determined.

- Many goals included some detail in the definition (operationalization) of the psychiatric indicator as noted above in indicator 4. In order for the goal to be measurable, the definition (operationalization) needs to more clearly describe exactly what it is that the person recording information needs to see. This is typically direct support professional staff, but sometimes might be behavioral health services staff or psychiatry staff (e.g., for rating scales). Those recorders need to know how to determine if a psychiatric indicator (symptom) is or is not occurring and if it should or should not be counted. For instance:
  - Crying was a psychiatric indicator for some individuals. Does it need to occur for a period of time to be counted?
  - Percent of opportunities was used for many indicators, especially for prosocial behaviors. This is often very difficult to determine and can vary from shift to shift and from staff to staff. A more measurable (and likely more reliable) definition is needed for these prosocial behaviors.

6. Goals (and their psychiatric indicators) must be related to the individual's assessment and diagnosis.

- At El Paso SSLC, goals were related to the individual's assessment and diagnosis or diagnoses. The Monitoring Team does not require that there be a separate goal for reduction and a separate goal for increase for every diagnosis. This indicator was scored 1 for each individual, except for Individual #104. In this case, the psychiatric indicator was aggression, however, a more typical psychiatric indicator for treatment with medications for individuals with autism is irritability. It is fine for aggression to be an additional psychiatric indicator (it already was a target behavior in the PBSP).

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

- Reliable data were reported for behavioral health services target and replacement behaviors for three of the individuals who were seen by psychiatry (Individual #192, Individual #104, Individual #159).
- There was no indication or report in the documentation as to whether the data on psychiatric indicators were reliable for the psychiatric indicators for these three individuals or for the other five individuals (Individual #179, Individual #9, Individual #26, Individual #30, Individual #153).
- Ensuring reliable data is an area of focus for the psychiatry department. Likely, accomplishing this will require collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.	
Summary: Some items were missing from many of the CPEs. This may be, at least in part, a function of the CPEs being a few years old and, therefore, requiring some updating to meet criteria. Psychiatry completed CPEs as required for new admissions, but some other admission-related documentation was not found. These three indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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.	38% 3/8	1/1	N/A	0/1	0/1	0/1	1/1	1/1	0/1	0/1
15	If admitted within two years prior to the onsite review, and was receiving psychiatric medication, an IPN from nursing and the primary care provider documenting admission assessment was completed within the first business day, and a CPE was completed within 30 days of admission.	0% 0/2	N/A	N/A	N/A	0/1	N/A	N/A	N/A	0/1	N/A
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.	38% 3/8	1/1	N/A	0/1	0/1	0/1	0/1	1/1	1/1	0/1

Comments:

14. The Monitoring Team looks for 14 components in the CPE. The evaluations regarding Individual #179, Individual #26, and Individual #30 met all the requirements. Four of the other evaluations lacked a sufficient bio-psycho-social formulation. This was the most common deficiency. One evaluation was lacking sufficient information in one element, one evaluation was lacking sufficient information in two elements, two evaluations were lacking sufficient information in three elements, and one evaluation was lacking sufficient information in five elements.

15. For the two individuals admitted in the two years prior to the onsite review, both had psychiatric evaluations performed within 30 days of admission. Neither individual, however, had integrated progress notes from primary care or nursing documenting an admission assessment completed within the first business day of admission.

16. There were five individuals whose documentation revealed inconsistent diagnoses: Individual #9, Individual #192, Individual #104, Individual #26, and Individual #153.

Outcome 5 – Individuals' status and treatment are reviewed annually.	
Summary: Psychiatry documentation for the ISP was submitted on time for all individuals. A next step for psychiatry and for the QIDP is to get the relevant information into the IRRF section of the ISP to address indicator 21. There are four sub-indicators and some detailed interpretive guidelines in the monitoring tool that should be helpful to the psychiatrist and QIDP. There was also a need for the Center to look at the way in which the psychiatrist was able to participate in annual ISP meetings and how that decision is documented. These indicators will remain in	Individuals:

active monitoring.											
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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).	29% 2/7	0/1	N/A	0/1	N/A	1/1	0/1	0/1	1/1	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.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.	0% 0/7	0/1	N/A	N/A	0/1	0/1	0/1	0/1	0/1	0/1
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:

18-19. The Monitoring Team scores 16 aspects of the annual evaluation document. Seven individuals required annual evaluations. All were completed over 10 days prior to the ISP meeting. Two of the evaluations, regarding Individual #104 and Individual #159, met all the requirements. Four evaluations were lacking one element and one evaluation was lacking two elements. The most common deficiency was the inclusion of past pharmacotherapy.

20. The psychiatrist did not attend the ISP meeting for any of the individuals in the review group. The Center reported that the IDTs determined that psychiatrist attendance was not needed for five of the individuals.

There needs to be some documentation that the psychiatrist participated in the decision to not be needed to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, there may have been psychiatric-related incidents, a change in medications, and so forth.

For the other three individuals, the IDT determined at the ISP preparation meeting that the psychiatrist should attend the annual ISP meeting. During the three annual ISP meetings, she was available via telephone if there were questions for her, but there weren't any, and she was not called and did not participate.

Thus, in looking at the status of the eight individuals, the Monitoring Team determined that there was insufficient rationale for there being no psychiatry participation in the annual meeting for seven of the individuals (all except Individual #9). Two individuals had polypharmacy medication regimens (Individual #30, Individual #159), one was a new admission (Individual #192), and one had side effects from medications (Individual #179). Three had ongoing significant psychiatric-related issues and the IDT had requested attendance during the ISP preparation meeting (Individual #104, Individual #153, Individual #26). One individual's psychiatric status was stable and the Monitoring Team did not disagree with the IDT's determination to not have psychiatrist attendance, though some documentation from the psychiatrist supporting this decision was not found (Individual #9).

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

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

Summary: PSPs were used for 10 individuals at El Paso SSLC. Given the Monitoring Team's findings, they should all receive review, attention, and updating. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 179	63	9	192	104	26	30	159	153
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	33% 1/3	N/A	N/A	N/A	N/A	N/A	N/A	0/1	N/A	N/A

Comments:
22. One individual in the review group, Individual #30, had a PSP. This document was out of date because it was implemented in September 2016. PSP examples were also requested for Individual #82 and Individual #89. The PSP for Individual #89 was complete and included all the required elements. The PSP regarding Individual #82 was out of date because it was implemented in 2015.

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

Summary: Signed consent forms existed for all medications for all individuals for this review and the last two reviews, too, with the exception of one medication in July 2016. Similarly, HRC reviews occurred as required for all individuals and all medications for this review and the last two reviews, too, with one exception in July 2016. Based on this sustained high performance, these two indicators (30, 32), will be moved to the category of requiring less oversight. Written information content also improved (indicators 29 and 31), too, since the last review. Risk-benefit information, however, needed to be included. These three indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 179	63	9	192	104	26	30	159	153
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	100% 8/8	1/1	N/A	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	100%	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

	regarding medication side effects was adequate and understandable.	8/8									
30	A risk versus benefit discussion is in the consent documentation.	0% 0/8	0/1	N/A	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.	75% 6/8	1/1	N/A	1/1	0/1	1/1	1/1	1/1	0/1	1/1
32	HRC review was obtained prior to implementation and annually.	100% 8/8	1/1	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
29. The consent forms included some medication side effect information. The facility routinely included a medication side effect information sheet with the consent forms. These information sheets contained sufficient information regarding medication side effects.

30. The risk versus benefit discussion was not included in the consent forms, but needs to.

31. The consent forms in six examples included individualized alternate and non-pharmacological interventions outside of the PBSP.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: Performance remained about the same as last time. It was good to see that some individuals had PBSP data that were reliable. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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	0/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The individual has goals/objectives related to psychological/behavioral health services, such as regarding the reduction of problem behaviors, increase in replacement/alternative behaviors, and/or counseling/mental health needs.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	86% 6/7	1/1	0/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	57% 4/7	1/1	1/1	N/A	0/1	1/1	1/1	N/A	0/1	0/1
5	Reliable and valid data are available that report/summarize the	57%	0/1	1/1	N/A	1/1	1/1	0/1	N/A	1/1	0/1

	individual's status and progress.	4/7									

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 #9, who did not have a PBSP at the time of the onsite review. She was reported to engage in SIB and physical aggression and, therefore, warranted a PBSP.

3. Individual #63's objectives were expressed as percent of intervals. His target behaviors, however, were expressed as frequency, therefore, progress toward his objectives was not measurable.

4. Individual #153, Individual #159, and Individual #192 had target behaviors in the PBSP (brief PBSP for Individual #159) that were not included in their functional assessment.

5. Individual #63, Individual #192, Individual #104, and Individual #159 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 #179 did not have DCT assessments in the last six months. Individual #26 and Individual #153 did have IOA and DCT assessments indicating that their PBSP data were reliable, however, they were scored 0 because of discrepancies in the frequency of restraints and target behaviors that suggested that their PBSP data were not reliable. For example, in October 2017, Individual #153 was reported have been restrained 17 times, however, the behaviors that provoke restraints (i.e., physical aggression, elopement, and SIB), were reported to occur only three times in the month of October (two incidents of aggression, one incident of SIB, zero incidents of elopement). Similarly, Individual #26 had 15 restraints in July 2018, however, five incidents of SIB and three incidents of aggression were recorded in that month.

The integrity of the PBSP data is critical to affecting effective behavior change. It is recommended that the Center's behavioral health services department learn why these discrepancies were occurring, and implement the necessary changes to ensure that PBSP data at El Paso SSLC are consistently reliable.

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

Summary: Performance did not remain high for indicators 10 and 11, though performance slightly improved for indicator 12. All three will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 179	63	9	192	104	26	30	159	153
10	The individual has a current, and complete annual behavioral health update.	89% 8/9	1/1	0/1	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).	71% 5/7	1/1	0/1	N/A	1/1	1/1	0/1	N/A	1/1	1/1
12	The functional assessment is complete.	71%	0/1	0/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1

		5/7									

Comments:
10. Individual #63's annual behavioral health update was dated 1/12/16.

11. Individual #63's functional assessment was dated 1/12/16. Individual #26's functional assessment was current, however, the direct and indirect assessments were more than one year old and therefore was scored as a 0

12. Individual #192, Individual #104, Individual #26, Individual #159, and Individual #153 had complete functional assessments. The Monitoring Team found Individual #192 and Individual #104's functional assessments to be particularly clear and through.

Individual #179's functional assessment was rated incomplete because the indirect assessment only included a target behavior that was not in the current PBSP. Individual #63's functional assessment was 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.

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

Summary: All three indicators showed decrease in performance compared with the last review. Attention needs to be paid to PBSP content, especially regarding consistency in target behavior identification and inclusion. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 179	63	9	192	104	26	30	159	153
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	29% 2/7	0/1	0/1	N/A	1/1	0/1	0/1	N/A	1/1	0/1
14	The PBSP was current (within the past 12 months).	71% 5/7	0/1	0/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
15	The PBSP was complete, meeting all requirements for content and quality.	0% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1

Comments:
13. There was documentation that PBSPs were implemented within 14 days of attaining all necessary consents/approvals for Individual #159 and Individual #192.

14. Individual #179's PBSP was dated 2/1/16. Individual #63's PBSP was dated 1/28/16.

15. The Monitoring Team reviews 11 components in the evaluation of an effective positive behavior support plan. None of the PBSPs were rated as containing all of these components.

- Individual #63, Individual #192 Individual #179, Individual #159 and Individual #153's PBSPs were rated as incomplete

because the target behaviors and/or treatment objectives in their PBSPs were different from those in their functional assessments and/or most recent progress note.

- Individual #26's PBSP did not contain his behavioral contract, a critical component of this PBSP.
- Individual #104's PBSP did specify that staff should reinforce his use of replacement behaviors, and did not specify how staff should respond if they cannot provide (e.g., the item is not available or not allowed) the item Individual #104 was requesting.

Ensuring consistency of target behaviors and treatment objectives across functional assessments, PBSPs, and progress notes should be a priority for the BHS department.

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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 #26's IDTs referred them for counseling. Individual #26 refused counseling and there was documentation that Individual #153 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: Some concerns were noted with regard to the timeliness of medical assessments. If such issues persist at the time of the next review, Indicator b might return to active oversight. Center staff also should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. Indicator c will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									

	on the individual's clinical needs.										
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: b. In reviewing annual medical assessments for other indicators, the Monitoring Team noted three late assessments. Individual #104's was two weeks late, Individual #90's was two days late, and Individual #103's was over a month late. If such issues persist at the time of the next review, this indicator might return to active oversight.

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: Center staff should continue to improve the quality of the medical assessments with particular focus on the plan of care section. Indicators a and c will remain in active oversight.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
a.	Individual receives quality AMA.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	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. Problems varied across the medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, family history, past medical histories, complete interval histories, allergies or severe side effects of medications, and lists of medications with dosages at the time of the AMA. Most, but not all included, as applicable, social/smoking histories, childhood illnesses, complete physical exams with vital signs, and pertinent laboratory information, 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. This was a problem across eight of the nine assessments reviewed, and requires focused attention. Often, this section did not include a status of the problem, etiology of the problem, and/or a plan to address the problem.

c. For nine individuals, a total of 18 of their chronic diagnoses and/or at-risk conditions were selected for review [i.e., Individual #192 – gastrointestinal (GI) problems, and neurological; Individual #104 – other: hyperprolactinemia, and other: hypothyroidism; Individual #90 – other: hyperlipidemia, and osteoporosis; Individual #103 – respiratory compromise, and constipation/bowel obstruction; Individual #82 – seizures, and osteoporosis; Individual #99 – cardiac disease, and diabetes; Individual #4 – other: kidney stones, and constipation/bowel obstruction; Individual #25 – GI problems, and other: anemia; and Individual #102 – other: deep vein thrombosis, and seizures].

As noted above, the ISPs/IHCPs reviewed generally 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. This indicator will remain in active oversight.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	33% 6/18	0/2	0/2	0/2	1/2	0/2	1/2	1/2	1/2	2/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	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 #192 – GI problems, and neurological; Individual #104 – other: hyperprolactinemia, and other: hypothyroidism; Individual #90 – other: hyperlipidemia, and osteoporosis; Individual #103 – respiratory compromise, and constipation/bowel obstruction; Individual #82 – seizures, and osteoporosis; Individual #99 – cardiac disease, and diabetes; Individual #4 – other: kidney stones, and constipation/bowel obstruction; Individual #25 – GI problems, and other: anemia; and Individual #102 – other: deep vein thrombosis, and seizures).

The IHCPs that sufficiently addressed the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations were those for: Individual #103 – constipation/bowel obstruction; Individual #99 – diabetes; Individual #4 – constipation/bowel obstruction; Individual #25 – GI problems; and Individual #102 – other: deep vein thrombosis, and seizures.

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

Dental

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: It was positive that the Dental Department completed annual dental summaries in a timely manner. The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams and summaries. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	63% 5/8	N/A	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 8/8	N/A	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
c.	Individual receives a comprehensive dental summary.	33% 3/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1	1/1

Comments: a. The following concerns were noted:

- On 3/20/17, the dentist completed an in-home exam for Individual #104, but on 3/8/16, the dentist indicated that an exam could not be completed.
- On 1/24/17, Individual #90 had a dental exam, but in response to the Monitoring Team's request for the previous dental exam, the Center indicated: "No previous annual dental exam was completed."
- Individual #82's annual dental exam was four days overdue.

b. It was positive that Individual #25's dental exam included all of the necessary information. It was good to see that the remaining dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- A description of periodontal condition/type;
- The recall frequency;
- Caries risk;

- Periodontal risk;
- Sedation use; and
- Specific treatment provided.

Most, but not all included:

- An oral cancer screening; and
- An odontogram (i.e., one in color so interpretation was possible).

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

- Information regarding last x-ray(s) and type of x-ray, including the date.
- A summary of the number of teeth present/missing;
- A treatment plan; and
- Periodontal charting.

c. It was positive that Individual #4, Individual #25, and Individual #102's dental summaries included all of the necessary components.

On a positive note, all of the remaining dental summaries included the following:

- Effectiveness of pre-treatment sedation;
- Recommendations related to the need for desensitization or another plan;
- A summary of the number of teeth present/missing;
- Dental care recommendations;
- Treatment plan, including the recall frequency; and
- Recommendations for the risk level for the IRRF.

Most included:

- A description of the treatment provided.

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

- Provision of written oral hygiene instructions; and
- Dental conditions that could cause systemic health issues or are caused by systemic health issues.

Nursing

Outcome 3 – Individuals with existing diagnoses have nursing assessments (physical assessments) performed and regular nursing assessments are completed to inform care planning.	
Summary: Due to previous high performance with regard to the completion of annual nursing reviews and physical assessments, Indicators a.i and a.ii moved to the category requiring less oversight. However, based on the annual nursing assessments the Monitoring Team used for other elements of its review, problems were noted with regard to the completion of complete physical assessments, including weight graphs, fall assessments, and assessments of reproductive systems. As a result, Indicators a.i and a.ii will move back to active monitoring. The	Individuals:

remaining indicators require continued focus to ensure nurses complete timely and thorough quarterly reviews, nurses complete quality nursing assessments for the annual ISPs, and that when individuals experience changes of status, nurses complete assessments in accordance with current standards of practice.											
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
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, at the time of the Round 11 review, they moved to the category requiring less oversight. However, due to regression with regard to the completion of comprehensive nursing reviews and physical assessments, these indicators will move back to active 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.	0% 0/9	0/1	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.	0% 0/10	0/2	N/A	0/2	0/1	N/A	0/1	0/1	0/1	0/2

Comments: a. Based on the Monitoring Team's use of annual nursing assessments and physicals for other elements of its review, problems were noted for all nine individuals with regard to completion of complete physical assessments, including weight graphs, fall assessments, Braden scores, and assessments of reproductive systems. In addition, abnormal findings (e.g., vital signs, pain) often did not result in further analysis, narrative, or follow-up. As a result, Indicators a.i and a.ii will move back to active monitoring. Similarly, quarterly physicals were missing these critical components.

Some of these issues appeared to be related to IRIS, and the State Office Discipline Lead was working to make changes to the system. However, other issues were unrelated to IRIS, and require corrections on the part of Center staff.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #192 – falls, and other: pica; Individual #104 – circulatory, and dental; Individual #90 – aspiration, and GI problems; Individual #103 – respiratory compromise, and skin integrity; Individual #82 – cardiac disease, and constipation/bowel obstruction; Individual #99 – diabetes, and GI problems; Individual #4 – weight, and constipation/bowel obstruction; Individual #25 – infections, and seizures; and Individual #102 – skin integrity, and UTIs).

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.

c. The following provide a few of examples of concerns related to nursing assessments in accordance with nursing protocols or current standards of practice in relation to individuals' changes of status:

- On 11/29/17 at 12:00 p.m., Individual #192 fell backwards while trying to obtain a soda, and sustained a mild head injury. The nurse wrote an IPN stating a head-to-toe assessment was completed, but details were not documented in IView or in the content of the IPN. In addition, nurses did not follow the applicable guidelines for following up on a head injury.
- On 10/7/17, Individual #192 ingested a foreign object, but nursing staff did not document an assessment in an IPN.
- For Individual #90, IView entries were missing from 6/1/17 through 11/1/17. As a result, nursing assessments could not be confirmed for changes of status, such as aspiration pneumonia on 9/8/17, or emesis on 6/7/17 times four, 6/8/17 times three, 6/10/17 times four, and/or 6/14/17.
- On 12/3/17 at 1:05 p.m., an initial nursing IPN noted a skin integrity issue for Individual #103 with a Stage III Nare decubitus. The nursing IPN did not describe the depth of the 0.5 centimeter (cm) by .25cm wide wound. It was described as "beef red." The follow-up entry, dated 12/3/17 at 1:46 p.m., indicated a change to simple mask oxygen. The next nursing entry was dated 12/4/17 at 2:25 p.m., and stated: "keeping 02 off for healing purposes." However, no IView entries were found for these dates showing nursing staff assessed the individual's vital signs.
- On 9/12/17, Individual #25 went to the hospital and was diagnosed with a UTI and upper respiratory infection. The first IView documentation that the Center provided was dated 9/25/17.
- On 11/25/17 and 11/28/17, Individual #102 had a skin tear to his coccyx requiring treatment. Nursing IPNs did not include the depth. The nursing IPNs also inconsistently noted whether or not there was drainage, odor, and/or associated pain. It was unclear whether staff categorized the skin tears. IPNs also did not describe nursing interventions to prevent further trauma.
- From 11/8/17 to 11/13/17, Individual #102 was hospitalized with extended spectrum beta-lactamases (ESBL) E. coli, and re-hospitalized on 11/14/17, for altered health status, tachypnea, and a fever. Despite this serious and contagious infection, nursing notes did not indicate when or if he was placed on contact precautions. In addition, nursing notes did not consistently provide information/analysis about his intake.

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 Score	192	104	90	103	82	99	4	25	102
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. though f. The IHCPs reviewed did not set forth plans to address individuals' at-risk conditions in accordance with SSLC nursing guidelines or current standards of practice. Often, nursing interventions were not included or were not comprehensive. Interventions often could not be measured, or did not define when nurses should implement them. Often preventative interventions were missing.											

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: Regression was noted with many of the indicators for this outcome. The PNMT Nurse position was vacant, which resulted in a lack of post-hospitalization reviews. Problems also were noted with regard to timely referral of individuals to the PNMT, timely completion of the PNMT initial review, and completion of PNMT comprehensive assessments for individuals needing them. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team	44% 4/9	2/2	0/1	0/1	0/1	N/A	N/A	1/2	0/1	1/1

	or PNMT.										
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	67% 6/9	2/2	0/1	1/1	0/1			1/2	1/1	1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	0% 0/3	0/2	N/A	0/1	N/A			N/A	N/A	N/A
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	56% 5/9	0/2	0/1	0/1	1/1			2/2	1/1	1/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	0% 0/5	N/A	0/1	0/1	N/A			0/2	N/A	0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	0% 0/9	0/2	0/1	0/1	0/1			0/2	0/1	0/1
g.	If only a PNMT review is required, the individual's PNMT review at a minimum discusses: • Presenting problem; • Pertinent diagnoses and medical history; • Applicable risk ratings; • Current health and physical status; • Potential impact on and relevance to PNM needs; and • Recommendations to address identified issues or issues that might be impacted by event reviewed, or a recommendation for a full assessment plan.	14% 1/7	N/A	0/1	0/1	0/1			0/2	0/1	1/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/3	0/2	N/A	0/1	N/A			N/A	N/A	N/A

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

- On 3/14/17, Individual #192 was admitted to El Paso SSLC. On 4/4/17, the PNMT initiated a review with regard to his emesis, and on 4/5/17, completed its review. The PNMT did not recommend a comprehensive assessment, but conducted follow-up. Between 3/15/17 and 4/15/17, he had nine episodes of emesis, with nine additional episodes through 5/15/17. Between 6/2/17 and 12/4/17, Individual #192 had at least 11 additional episodes of emesis. During the onsite review, staff reported four episodes more between 12/10/17 and 1/3/18. Given the frequency of emesis as well as the lack of a clearly established etiology, the PNMT did not provide sufficient justification for not completing a comprehensive assessment.

  With regard to falls, on 4/26/17, the IDT made changes to his level of supervision and level of assistance for mobility due to his experiencing no falls since admission. The IDT modified Individual #192's PNMP to discontinue his gait belt and upgrade his mobility status to functional independence with steadying assistance. This change reportedly resulted in two falls (i.e., on 4/26/17, and 4/27/17). The IDT's documented discussion indicated that staff did not know the difference between the level of supervision and the level of assistance, and that staff had not followed the PNMP as he was observed walking on campus with

no direct support professional staff nearby or in sight. The PNMT became involved when he experienced an increase in falls in October 2017 (i.e., at least 11 falls before the PNMT review, dated 10/18/17). Since the PNMT review, he fell at least seven times. The PNMT did not conduct a comprehensive assessment, but did not provide a rationale for not conducting one. Although the PNMT concluded in its review that the falls were related to "poor balance," sufficient assessment was not completed to identify the underlying cause of his poor balance.

- On 11/8/17, the PNMT wrote a note following up on Individual #104's ingestion of a foreign object, and on 11/29/17, the PNMT wrote a note related to weight loss. However, the PNMT did not, though, conduct a formal review of his weight history and weight gain since at least July 2016. More specifically, his weight history showed weight loss in 2016 of 27.6 pounds, but then in July 2017, he gained approximately nine pounds (i.e., from 188.2 to 197), and again, gained approximately nine pounds between September to November 2017 (i.e., 199.6 pounds to 209 pounds). In November 2017, he reportedly lost 19 pounds (i.e., 209 pounds on 11/8/17 to 190 pounds on 11/14/17), which then triggered a PNMT review. On 11/29/17, the PNMT discussed him and wrote an IPN related to weight loss of 9%, secondary to a hospitalization, from 11/8/17 to 11/13/17, with a clear liquid diet after swallowing a hyper-dense tubular object. Overall, though, he has continued to gain weight, as he was 191.6 pounds on 11/27/17, 206 on 12/11/17, and 213 on 1/4/18. At least, a PNMT review of his weight gain was warranted.
- During the few years prior to his death on 12/26/17, the PNMT reviewed Individual #90 a number of times. The PNMT's recommendations from a previous assessment(s) were re-referral if he were to drop below 94 pounds, which they had determined was a critical weight for him; another diagnosis of aspiration pneumonia; or a Stage III decubitus ulcer. The last two criteria were not individualized to address his specific history and needs.
    - On 5/1/17, the PNMT conducted a review for a skin tear the PCP noted on 4/26/17. According to information the Center submitted as part of Tier I documentation, on 5/16/17, this was categorized as a Stage II decubitus on his coccyx. On 8/1/17, an open wound on his buttock, which was originally discovered on 7/13/17, was categorized as a Stage II decubitus. In its 5/1/17 review, the PNMT reported that he had experienced two Stage II pressure ulcers in 12 months, which met criteria for referral. Likely, this should have resulted in a comprehensive assessment, and the evaluation did not recommend one or provide a rationale for why not.
    - On 6/7/17, the PNMT conducted another review related to weight loss of 9.3% in one week. At this time, the PNMT should have initiated a comprehensive assessment, but did not, particularly given that he reportedly had at least 10 episodes of emesis between 6/7/17, and 6/10/17.
    - From 6/15/17 to 6/20/17, Individual #90 was hospitalized for weight loss and dehydration, with a discharge diagnosis of bowel obstruction, according to the PNMT review.
    - From 6/21/17 to 6/25/17 Individual #90 was hospitalized for aspiration pneumonia. On 6/26/17, the IDT referred him to the PNMT with a possible diagnosis of pneumonia, although it had not been confirmed. According to a note on 6/26/17, the PNMT indicated that they would initiate a review within five days. From 7/12/17 to 7/13/17, Individual #90 was again hospitalized with another diagnosis of aspiration pneumonia.
    - The PNMT's assessment, completed on 7/26/17, was to address weight loss, aspiration pneumonia, multiple hospitalizations and ED visits, and decreased tolerance to increasing feeding/water.
- Based on the documentation provided, it was unclear when Individual #103's IDT referred her to the PNMT. On 5/1/17, she met criteria for referral due to a weight loss of 7.65% between 4/4/17 and 5/1/17. The PNMT did not review her until 5/15/17. Between 4/4/17 and 6/28/17, she experienced a total weight loss of 12.68% (i.e., 83.6 to 73 pounds). In its review, the PNMT did not report the circumstances of Individual #103's weight loss, but merely listed her diagnoses. The PNMT did

not report lab values or whether there were changes from previous testing, but rather only stated that they appeared normal. The review stated that her core temperatures were low. The documentation provided no evidence that the PNMT explored whether staff were administering her enteral nutrition as prescribed, nor was there discussion of her current actual rate of intake. The PNMT made recommendations to monitor weekly weights, consider an increase in tube feeding rate if weight loss continued, and for a referral to medical related to low core temperatures. The PNMT provided no indication that they planned to explore her actual intake, residuals, or the weight at which an increase in nutrition was indicated. The PNMT also did not discuss whether her risk level should be modified.

- For Individual #4:
  - On 5/15/17, the PNMT conducted a review of his bacterial pneumonia, for which he was hospitalized from 5/7/17 to 5/12/17. In addition, from 7/20/17 to 7/24/17, he was hospitalized with a discharge diagnosis was urosepsis, but according to a chest x-ray at the hospital, aspiration pneumonia could not be ruled out. Although the PNMT conducted a post-hospitalization review, they did not make a self-referral. From 8/13/17 to 8/15/17, Individual #4 was subsequently hospitalized for aspiration pneumonia, and it was not until after that hospitalization that the PNMT conducted a review.
  - On 6/21/17, the PNMT reviewed Individual #4 for weight loss, and the explanation provided was that he met criteria when he lost 5.025% of his body weight in 30 days (i.e., 83.60 pounds on 5/1/17 to 79.80 pounds on 6/21/17, which is actually a 4.5% loss of body weight). However, on 5/15/17, Individual #4 weighed 78.2 pounds, which represented a 6.46% loss since 5/1/17. The IDT should have referred him to the PNMT over a month earlier than they did. In its review, the PNMT did not address Individual #4's current health beyond weight and the hospital admission the previous month. Similar to the PNMT's review related to pneumonia, this review did not justify why they did not do a comprehensive assessment, but rather, they just marked that he did not need one.
- Within the 30-day period between 10/9/17 and 11/6/17, Individual #25 gained more than 5% of her body weight. On 11/8/17, the PNMT completed a progress note. The note did not address the individual's medical history and diagnoses, or risk areas. The PNMT stated that the weight gain likely was secondary to the addition of Ensure Clear, adding 720 calories per day and that they would meet with IDT to recommend changes to her diet for weight maintenance. However, no evidence was found that during an ISPA meeting held on 11/13/17, the PNMT made specific recommendations.
- With regard to Individual #102's enteral nutrition, he had a tube placed in 2015, secondary to hydration issues, but he continued with oral intake. On 3/9/17, the tube was removed and not reinserted with a request for a fluid intake schedule. The PNMT conducted a review, but due to inadequate intake, the decision was to replace the tube and this occurred on 4/19/17. Subsequently, on 4/24/17 and 4/26/17, the PNMT conducted a review relative to the new tube placement. The PNMT and IDT discussed a plan for the use of the G-tube, as well as continued oral intake as the primary means of nutrition, and a plan to discontinue the tube in the future (i.e., if it was not used for six months). Unfortunately, at the ISPA meeting on 5/1/17, this plan was not translated into the ISP/IHCP in a manner that was coherent and measurable.

e. and f. At the time of the review and in the months preceding the review, the PNMT did not have an assigned RN.

h. As noted above, two individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #192 for emesis and falls, and Individual #90, who should have had a comprehensive assessment sooner than he did).

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: No improvement was seen with regard to these indicators. Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
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).	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	33% 3/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	11% 2/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	1/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	1/2	0/2	0/2	0/2	1/2	1/2	0/2	1/2	1/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: GI problems, and falls for Individual #192, choking, and weight for Individual #104; weight, and skin integrity for Individual #90; aspiration, and weight for Individual #103; falls, and choking for Individual #82; choking, and weight for Individual #99; aspiration, and weight for Individual #4; weight, and falls for Individual #25; and other: return to oral eating, and skin integrity for Individual #102.

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 falls for Individual #82, and falls for Individual #25.

c. Eight of the nine individuals reviewed had PNMPs and/or Dining Plans. It was positive that the PNMPs for Individual #103, Individual #82, and Individual #25 included all of the necessary components to meet the individuals' needs. Problems varied for the remaining individuals. For example:

- Individual #104 did not have a PNMP or Dining Plan. Based on an observation, he ate large quarters of a sandwich with a fork, which were not cut into bite-sized pieces. These circumstances presented a significant choking risk. Staff required prompting

to cut his food, because he was not able to cut it himself. Staff stated that the diet card indicated that he could eat sandwiches cut into quarters, which would only be safe if he picked it up and ate it like a sandwich, taking smaller bite-sized pieces. Individual #104 also had adaptive equipment for mealtime. Based on these factors, he appeared to meet the general criteria for at least a Dining Plan, if not a full PNMP. While on site, the Monitoring Team member discussed these concerns with the Habilitation Director.

- Individual #90's PNMP was last reviewed on 7/28/17, despite his continuing decline. In its comments on the draft report, the State indicated that the reason for the lack of review was that Individual #90 was subsequently hospitalized from 9/25/17 until he died on 12/26/17. This does not account, though, for the two-month period prior to his final hospitalization during which further review was needed.
- Individual #192's PNMP did not address his GI risk, and Individual #102's PNMP did not include triggers for his skin issues.
- Individual #99 only had a Dining Plan, so needed instructions were missing with regard to transfers, mobility, bathing, toileting, oral hygiene, and handling.
- Some individuals' communication instructions did not include how staff should communicate with them.

d. The IHCPs for falls for Individual #82, and falls for Individual #25 identified the action steps necessary to meet the identified objectives.

e. The IHCPs reviewed that identified the necessary clinical indicators were those for weight for Individual #90; and falls for Individual #25.

g. Often, the IHCPs reviewed did not include the frequency of PNMP monitoring. Those that did were for falls for Individual #192, choking for Individual #82, falls for Individual #25, and other: return to oral eating for Individual #102.

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	192	104	90	103	82	99	4	25	102
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.	33% 1/3	N/A	N/A	0/1	1/1	N/A	N/A	N/A	N/A	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% 0/2			0/1	N/A					0/1

Comments: a. and b. Individual #103's IRRF provided a justification for the use of enteral nutrition. For the remaining two individuals, such justification was not found.

As discussed elsewhere in this report, Individual #102 had a tube placed in 2015, secondary to hydration issues, but he continued with oral intake. On 3/9/17, the tube was removed and not reinserted with a request for a fluid intake schedule. The PNMT conducted a review, but due to inadequate intake, the decision was to replace the tube and this occurred on 4/19/17. His IDT only stated that if the tube was not used for six months, they would consider taking it out. The IDT did not establish any other milestones, or address issues such as refusals (e.g., one refusal would mean continuation of the tube), adequate hydration, etc. to ensure that removal of the tube could occur safely, and that he continued to receive nutrition using the least restrictive method.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.

Summary: A significant issue was that Center staff had not followed the current guidelines for considering when an OT/PT comprehensive should be repeated. For a number of individuals reviewed, the three-year mark had passed, and OTs/PTs had not completed a new comprehensive assessment, or justified why an update met the individual's needs. The OT/PT updates reviewed generally met criteria, which was good to see. The comprehensive assessment reviewed needed improvement. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
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.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	25% 2/8	N/A	0/1	0/1	0/1	0/1	0/1	0/1	1/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	22% 2/9	1/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1

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% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A

Comments: a. and b. The following concerns were noted:

- For Individual #104, the Center did not submit the last OT/PT assessment or screening. On 3/7/17 and 3/8/17, the OT and PT, respectively, provided documentation to address questions that the IDT raised during the pre-ISP meeting. Based on review of these documents and observation, he appeared to be functionally mobile, but the OT consultation indicated that he required at least prompting for activities of daily living. At a minimum, the OT/PT should have completed a screening, and because the Center did not submit the most recent assessment, it was unclear whether a comprehensive assessment was needed to establish a baseline.
- According to the OT/PT update submitted, Individual #90's last comprehensive assessment was completed on 1/30/13. According to current guidelines included in the audit tool, the OT/PT should have considered completing a comprehensive assessment in 2016. Similarly, Individual #103's last comprehensive reportedly was completed on 9/16/13, Individual #82's was completed on 5/1/13, and Individual #4's was completed on 5/31/13.
- The Center did not submit a screening or assessment for Individual #99.
- Individual #102 had an update completed, but because the Center did not submit the comprehensive assessment, dated 5/22/17, the Monitoring Team could not determine whether or not an update met his needs. In its comments, the State indicated that the OT/PT "considered" another comprehensive assessment. As stated in the draft report, without a copy of the original comprehensive assessment, the Monitoring Team could not determine whether or not the OT/PT made the correct decision.

d. As discussed above, OTs/PTs did not follow current guidelines for many of the individuals reviewed by considering the need to repeat a comprehensive assessment at the three-year mark. In addition, the Center did not submit the most recent comprehensive assessments for these individuals. As a result, most individuals received a negative score for this indicator. The Monitoring Team reviewed the comprehensive OT/PT assessment for Individual #192, who was newly admitted. The following summarizes some of the problems noted:

- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports: Individual #192 was newly admitted, and the assessment did not address this fact and its impact on accurately identifying his risks. However, despite issues with emesis, the assessors stated he was at low risk for choking and aspiration;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services: Clinical justification was not offered for why he would not benefit from direct PT intervention to address falls; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need: As noted above, recommendations for direct therapy should have been considered or justification provided for not making such recommendations.

On a positive note, Individual #192's comprehensive OT/PT assessment included:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living; and
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.

e. It was positive that the OT/PT appropriately completed an update for Individual #25 and it met criterion in that it thoroughly assessed her OT/PT strengths, needs, and incorporated her preferences. Unfortunately, although OT/PT updates had been completed for a number of individuals, as discussed above, these individuals were overdue for at least consideration for a comprehensive assessment. As feedback for the Center, generally, these other updates also were thorough, and met criteria.

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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	44% 4/9	0/1	0/1	0/1	0/1	1/1	1/1	0/1	1/1	1/1
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.	0% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1

c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	33% 1/3	N/A	N/A	0/2	N/A	1/1	N/A	N/A	N/A	N/A
d.	When a new OT/PT service or support (i.e., direct services, PNMPs, or SAPs) is initiated outside of an annual ISP meeting or a modification or revision to a service is indicated, then an ISPA meeting is held to discuss and approve implementation.	100% 1/1	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A
Comments: b. Simply including a stock statement such as "Team reviewed and approved PNMP" did not provide evidence of what the IDT reviewed, revised, and/or approved. c. and d. Individual #90's goals/objectives for direct PT for ambulation, and for walking were not included in the actions plans. It was good to see his IDT added the direct PT program for transfers through an ISPA.											

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: A significant issue was that Center staff had not followed the current guidelines for considering when a comprehensive communication assessment should be repeated. For a number of individuals reviewed, the three-year mark had passed, and SLPs had not completed a new comprehensive assessment, or justified why an update met the individual's needs. As a result, Indicator b will return to active oversight. The communication updates reviewed needed significant improvements. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/R	N/A	N/A	N/A
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10	100%	N/A	1/1	1/1	1/1	1/1		1/1	1/1	1/1

	days prior to the ISP meeting, or based on change of status with regard to communication.	7/7									
b.	Individual receives assessment in accordance with their individualized needs related to communication.	Due to the Center's sustained performance with this indicator, at the time of the last review, it moved to the category requiring less oversight. However, due to concerns identified during this review, Indicator b will return to active 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.	100% 1/1	1/1	N/A	N/A	N/A	N/A		N/A	N/A	N/A
d.	Individual receives quality Comprehensive Assessment.	0% 0/6	N/A	0/1	0/1	0/1	0/1		0/1	N/A	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/1	N/A	N/A	N/A	N/A	N/A		N/A	0/1	N/A

Comments: Individual #99 had functional communication skills and was part of the outcome group, so these indicators were not reviewed for him.

b. At the time of the last review, Indicator b moved to less oversight due to sustained performance. However, based on the Monitoring Team's review of communication assessments for other indicators, problems were noted with regard to the completion of the correct type of assessment. As a result, this indicator will return to active oversight. The following provides information about problems noted:

- According to the communication update submitted, Individual #104's last comprehensive assessment was completed in 2013. According to current guidelines included in the audit tool, the SLP should have considered completing a comprehensive assessment in 2016. In 2017, the SLP completed an update stating Individual #104 was "stable," and it would be discussed with the IDT. This discussion should have occurred at the pre-ISP meeting, and clinical justification provided if the decision

was not to repeat a comprehensive assessment. Similar issues were noted for Individual #82, and Individual #4.

- Individual #90's last comprehensive evaluation was not submitted, so the appropriateness of an update could not be determined. The same issue was noted for Individual #103, and Individual #102.

c. It was good to see that the SLP conducted a thorough screening to assess Individual #192's support needs.

d. As discussed above, SLPs did not follow current guidelines for most of the individuals reviewed by considering the need to repeat a comprehensive assessment at the three-year mark. In addition, the Center did not submit the most recent comprehensive assessments for these individuals. As a result, most individuals received a negative score for this indicator.

e. The SLP for Individual #25 provided justification for the completion of an update. The following provide examples of concerns noted with regard to the required components of the communication update for Individual #25 (other updates submitted had similar concerns):

- The effectiveness of current supports, including monitoring findings: Although monitoring dates were listed, it was unclear whether or not communication was monitored, or if the monitoring pertained to mealtime. Specific data related to communication supports were not provided;
- 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: The SLP did not clearly justify why Individual #25 would not benefit from direct therapy related to use of a switch, for example, given that the SLP described the individual's great interest in the battery-operated dog and how the individual watched the clinician's hand for activation; 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: The assessment included a vague recommendation for development of a SAP related to the dog and the switch.

On a positive note, the update did sufficiently address:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication (this was not consistent across updates submitted, though);
- The individual's preferences and strengths are used in the development of communication supports and services: The SLP did an excellent job of describing the individual's skills and how they were not consistent with the goal the IDT proposed in the ISP preparation meeting: "will communicate when she wants the radio turned on" (this was not consistent across updates submitted, though);
- 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	192	104	90	103	82	99	4	25	102
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.	38% 3/8	0/1	0/1	0/1	1/1	0/1	N/R	1/1	0/1	1/1
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	14% 1/7	N/A	0/1	0/1	1/1	0/1		0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	57% 4/7	N/A	2/2	1/1	1/1	0/1		0/1	0/1	N/A
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									
Comments: a. For a number of individuals, ISPs did not provide complete descriptions of how they communicate, and particularly, how others should communicate with them. In a number of instances, the individuals' communication assessments included this information, but only portions of the relevant information were transferred to the ISPs. c. ISPs often did not document IDTs' discussions about individuals' communication dictionaries. Simply stating the communication dictionary had been approved did not provide evidence of the IDT's discussion and decision-making.											

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: Behavioral health services was recently assigned responsibility for SAPs (December 2017). It is likely that performance will improve over the next review period. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153

1	The individual has skill acquisition plans.	89% 8/9	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
2	The SAPs are measurable.	83% 19/23	None	3/3	3/3	3/3	3/3	2/3	1/3	1/2	3/3
3	The individual's SAPs were based on assessment results.	0% 0/23	None	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3
4	SAPs are practical, functional, and meaningful.	43% 10/23	None	2/3	2/3	0/3	2/3	1/3	0/3	1/2	2/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	0% 0/23	None	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3

Comments:

1. The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were no SAPs available to review for Individual #179, and two SAPs available for Individual #159, for a total of 23 SAPs for this review.

2. The majority of SAPs were measurable (e.g., Individual #153's identify street signs). Some SAPs, however, did not indicate the objective's prompt level (e.g., Individual #30's operate a switch SAP) or number of prompts (e.g., Individual #26's identify his medication) and, therefore, were not measurable.

3. Functional skills summary sheets were available for review, however, no functional assessments were available for review, therefore, this indicator was scored 0 for all individuals.

4. Forty-three percent of the SAPs were judged to be practical and functional (e.g., Individual #26's use kitchen safety skills 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 #26's identify his medication SAP). Other SAPs appeared practical, but were not related to the individual's ISP vision statement (e.g., Individual #192's brush his teeth SAP) and, therefore, were scored as 0 for this indicator.

5. None of the SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. The behavioral health services department recently initiated integrity and reliability assessments for SAPs. At this point it is recommended that a plan to ensure that all SAPs at El Paso SSLC will be assessed at least every six months should be established.

Outcome 3 - All individuals have assessments of functional skills (FSAs), preferences (PSI), and vocational skills/needs that are available to the IDT at least 10 days prior to the ISP.											
Summary: FSAs were not being conducted for any individuals. Therefore, indicator 10 will be returned to active monitoring. The other two indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	179	63	9	192	104	26	30	159	153

		Score									
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight. However, due to there being no FSAs for any individuals, this indicator will be returned to active monitoring.									
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.	22% 2/9	0/1	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1

Comments:

10. No individuals had FSAs (see indicator 3).

11. No individual's FSAs, PSIs, and vocational assessments were available to the IDT at lease 10 days prior to the ISP.

12. Individual #30 and Individual #192's FSA cover sheets (the full FSAs were either not completed or not submitted) and vocational assessments included 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, 20 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, five other indicators were added to this category, in psychiatry and behavioral health services. One indicator in dental, however, was 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, integrated progress reports with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action.

In psychiatry, without measurable goals and objectives that met the criteria for indicators 4-7, progress could not be determined.

El Paso SSLC had a functioning neuro-psychiatry clinic that includes a neurologist and psychiatrist as well as other IDT members. As such, collaboration regularly occurred. The clinic was observed during the monitoring visit and was noted to be comprehensive, organized, and collaborative.

Psychiatry and neuropsychiatry clinics were observed. These were strengths of the Center. The clinics were organized, comprehensive, and well run. Each discipline presented their information in clinic and the providers did a good job of using the available data to make medication decisions.

Polypharmacy committee meeting was observed. It was well run and included a good review of the polypharmacy statistics, changes in orders, and specific regimens. For side effect monitoring, however, there were delays in conduct of both assessments and the prescriber review of the assessments for some individuals.

Behavioral health services progress notes needed to improve by being done every month and by including the graphs of PBSP target and replacement behaviors that were being made each month anyway. Data were presented in various meetings and follow-up occurred as per peer review requirements. The frequency/regularly of internal and external peer review needs to be improved.

Acute Illnesses/Occurrences

Regarding frequent restraint, there was improvement in that IDTs were meeting after occurrences of more than three restraints in any rolling 30-day period (indicators 1 and 2), but not the required review of variables and actions as required (indicators 20-23).

In psychiatry, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments, consultation with medical specialists, and alterations to non-pharmacological interventions) were developed and implemented.

Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected.

Significant problems continued to be noted with regard to the quality of PCPs' assessment of acute issues, provision of timely treatment and/or interventions for the acute illness, as well as PCPs' follow-up to acute illnesses and occurrences. In addition, IDTs, including the PCP, need to focus on holding post-hospital ISPA meetings to address follow-up medical and healthcare supports to reduce risks and promote early recognition, as appropriate.

It was good to see that the one individual reviewed who required emergency dental care received it in a timely and complete manner.

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. For less than half of the IHCPs reviewed, documentation was found to show implementation of those action steps assigned to the PCPs. In addition, significant work is needed to ensure that for individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care are completed, and the PCPs identify the necessary treatment(s), interventions, and strategies, as appropriate.

The Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate.

The Center also should focus on ensuring medical practitioners review and address, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

A number of individuals reviewed had not had needed dental treatment, such as prophylactic care, x-rays, and fluoride treatment. Over the past several reviews, these have been consistent findings. Center staff need to take steps to correct these lapses in care.

Since the last review, improvement was noted with regard to the Clinical Pharmacist's review of laboratory results, and the inclusion of recommendations in QDRRs, as appropriate. It also was positive that the PCPs responded to the Pharmacist's recommendations in QDRRs, as well as to interventions related to new medication orders.

Proper fit of adaptive equipment was sometimes still an issue.

Based on observations, there were still numerous instances (43% of 46 observations) in which staff were not implementing individuals' PNMPs or were implementing them incorrectly. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them.

In behavioral health, one individual had data that could be used for determining progress according to the criteria for this indicator (3), but the objective and the data collection did not line up correctly. For individuals who the Center described as not progressing, actions were developed for four of the six, and implemented for those four.

Just less than half of the individuals had most of their staff trained on their PBSPs. This was an improvement from the 0% scores on the previous three reviews. Similarly, PBSP summaries were available and certified behavior analysts oversaw PBSP development.

El Paso SSLC's data collection systems adequately measured target and replacement behaviors and the Center set treatment and data integrity measures and goals. These data collection targets, however, were not being met.

A number of individuals with complicated behavioral and psychiatric disorders were described as having made progress; some of them were in the Monitoring Team's review group and some were not (e.g., Individual #13, Individual #9, Individual #153). Good progress was reported for some of them in regards to restraint frequencies, activity participation, and psychiatric indicator presentation. The Center staff talked about the various Center departments and staff developing programming modifications.

For one individual whom the Monitoring Team reviewed during past visits, however, a great deal of decompensation was reported and observed (Individual #181).

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: There was improvement in that IDTs were meeting after occurrences of more than three restraints in any rolling 30-day period (indicators 1 and 2), but not the required review of variables and actions as required (indicators 20-23). Crisis intervention plans existed for each of these individuals as well as for all individuals for the last two reviews, too. Therefore, indicator 24 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	26	159	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.	100% 3/3	1/1	1/1	1/1						
19	If the individual reviewed had more than three crisis intervention restraints in any rolling 30-day period, a sufficient number of ISPAs existed for developing and evaluating a plan to address more than three restraints in a rolling 30 days.	100% 3/3	1/1	1/1	1/1						
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	0% 0/3	0/1	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% 0/3	0/1	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?	33% 1/3	0/1	0/1	1/1						

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.	33% 1/3	0/1	1/1	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% 3/3	1/1	1/1	1/1						
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	100% 3/3	1/1	1/1	1/1						
26	The PBSP was complete.	N/A	N/A	N/A	N/A						
27	The crisis intervention plan was complete.	33% 1/3	0/1	1/1	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.	100% 3/3	1/1	1/1	1/1						
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 3/3	1/1	1/1	1/1						

Comments:
18-29. This outcome and its indicators applied to Individual #26, Individual #159, and Individual #153.

18. Individual #26 had his fourth restraint in 30 days on 9/19/17, and his ISPA met on 9/28/17 to address these restraints. Individual #159 had his fourth restraint in 30 days on 8/7/17, and the IDT met to discuss these restraints on 8/8/17. Individual #153 had 17 restraints on 10/23/17, IDT met to review these restraints on 10/27/17.

20. Individual #153's 10/23/17 ISPA meeting discussed the role of anxiety concerning his upcoming move to the community as potentially affecting his restraints, however, no plan to address this potential contributor to restraints was documented in the ISPA minutes. A discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, was not found in either Individual #26's 9/19/17 or Individual #159's 8/7/17 ISPAs.

21. There was no documentation of the potential role of contributing environmental variables in Individual #26's 9/19/17, Individual #159's 8/7/17, or Individual #153's 10/23/17 ISPAs.

22. In Individual #153's 10/23/17 ISPA the IDT hypothesized that an antecedent to his dangerous behavior that provoked restraint was that he could not meet with a staff member. The team suggested the use of a visual calendar so Individual #153 could better understand when desired activities could be rescheduled. Individual #26's 9/19/17 ISPA hypothesized that not receiving the number

of coupons he expected was an antecedent to the dangerous behavior that provoked his restraint. There was, however, no documentation of a plan to address Individual #26 not getting desired items in the future. The potential role of antecedents was not addressed in Individual #159's 8/7/17 ISPA.

23. Individual #159's 8/7/17 ISPA hypothesized that not being able to immediately cash in his coupons may have contributed to his restraints, and the team decided to instruct staff that they should always cash in Individual #159's coupons immediately. The role of variables maintaining dangerous behaviors provoking restraint was not addressed in either Individual #26's 9/19/17 or Individual #153's 10/23/17 ISPAs.

27. Individual #159's CIP was complete. Individual #26's and Individual #153's CIPs, however, did not clearly state the behaviors that warrant restraint.

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. Indicators 2 and 3 were not applicable to any individuals in the review group and will remain in active monitoring for review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
1	If not receiving psychiatric services, a Reiss was conducted.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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	N/A	N/A	N/A	N/A	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	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments:											

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.	
Summary: As noted for outcome 2, good progress was occurring in the development of psychiatry-related goals. Once more complete, progress can be determined and indicators 8 and 9 can be scored. Even so, when an individual was deteriorating or was having worsening psychiatric condition, actions were taken by the psychiatrist and IDT, and these actions were implemented. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
8	The individual is making progress and/or maintaining stability.	0% 0/8	0/1	N/A	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% 0/8	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1	0/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 7/7	1/1	N/A	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	N/A	N/A	1/1	1/1	1/1	1/1	1/1	1/1

Comments:
8-9. Without measurable goals and objectives that met criteria for indicators 4-7, progress could not be determined. Thus, the first two indicators are scored at 0%.

10-11. It was apparent that when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments, consultation with medical specialists, and alterations to non-pharmacological interventions) were developed and implemented. This was the case for all individuals in the review group with the exception of Individual #9. There was documentation in the psychiatry notes describing Individual #9 as experiencing psychiatric stability, as such, revisions to her treatment plan were not needed.

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

Summary: Psychiatry continued to reference behavioral targets; some of the behavioral health documentation needed to reference the psychiatric variables (and/or were out of date). These two indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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.	50% 4/8	0/1	N/A	0/1	0/1	0/1	1/1	1/1	1/1	1/1
24	The psychiatrist participated in the development of the PBSP.	72% 5/7	0/1	N/A	0/1	1/1	1/1	1/1	N/A	1/1	1/1

Comments:
23. The psychiatric documentation regularly referenced the behavioral health target behaviors as well as the psychiatric symptoms for monitoring.

The behavioral health information regarding Individual #179 was out of date because the functional assessment was performed

11/29/16. The functional assessment regarding Individual #9 was incomplete because the diagnosis of PTSD was not considered as a variable contributing to this individual's behavioral challenges. The functional assessment regarding Individual #192 indicated that the target behaviors identified were influenced purely by environmental variables and did not take the psychiatric diagnosis into account.

24. There was documentation or indication that the psychiatric provider participated in the development of the PBSP for five of the seven individuals who had a PBSP. Although there was psychiatric documentation regarding participation in the development of the PBSP for Individual #179, the PBSP was out of date. The PBSP for Individual #9 was not included in the documents for review because it was reportedly pending an update. Individual #30 did not have a PBSP, rather, this individual has a PSP.

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: El Paso SSLC had a functioning neuro-psychiatry clinic that includes a neurologist and psychiatrist as well as other IDT members. As such, collaboration regularly occurred. The clinic was observed during the monitoring visit and was noted to be comprehensive, organized, and collaborative. These indicators (which are already in the category of requiring less oversight) did not apply to any of the individuals in the review group because none of them were being prescribed a medication for a dual use. However, that being said, five of the individuals were seen in neuro-psychiatry clinic for other neurology-related reasons (Individual #179, Individual #153, Individual #104, Individual #30, Individual #153). This was good to see.			Individuals:								
#	Indicator	Overall Score									
25	There is evidence of collaboration between psychiatry and neurology for individuals receiving medication for dual use.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
26	Frequency was at least annual.										
27	There were references in the respective notes of psychiatry and neurology/medical regarding plans or actions to be taken.										
Comments:											

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

Summary: Psychiatry clinics were a strength of the El Paso SSLC psychiatry department's service. All criteria were met regarding clinics for some time now. As a result, indicator 35 will be moved to the category of requiring less oversight. For some individuals, the quarterly review occurred late and for some, the content of	Individuals:

the documentation was missing an element. These two indicators will remain in active monitoring.											
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
33	Quarterly reviews were completed quarterly.	75% 6/8	1/1	N/A	1/1	1/1	1/1	0/1	1/1	0/1	1/1
34	Quarterly reviews contained required content.	38% 3/8	0/1	N/A	0/1	0/1	1/1	0/1	1/1	0/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	100% 3/3	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1

Comments:

33. Quarterly reviews were generally completed in a timely manner. There were two individuals whose records revealed delays in quarterly reviews. Quarterly evaluations regarding Individual #26 were performed 1/26/17 and 9/5/17 with an annual evaluation dated 6/1/17. There was no quarterly evaluation performed in March 2017. There was a quarterly evaluation regarding Individual #159 dated 1/3/17 with an annual evaluation dated 5/16/17. The annual evaluation or a quarterly review should have been performed in April 2017.

34. The Monitoring Team looks for nine components of the quarterly review. The reviews for three individuals included all the necessary components. The remaining five examples were missing one element. The missing element was either whether the non-pharmacological interventions recommended by the psychiatrist and approved by the IDT were being implemented, or the results of the most recent MOSES and AIMS assessments.

35. None of the individuals had psychiatry clinic during the monitoring visit. Two individuals, however, Individual #179 and Individual #153, were seen in neuro-psychiatry clinic and the clinical encounters were observed. The clinics were well run, organized, and comprehensive.

Psychiatry clinic was observed for individuals not included in the review, and were also comprehensive, meeting all of the Monitoring Team's criteria (Individual #82, Individual #89, Individual #81). The clinic encounters were a strength at this facility.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.											
Summary: Performance remained about the same as at the last reviews. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	25% 2/8	0/1	N/A	1/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:

36. There were delays in conduct of both assessments and the prescriber review of the assessments. For example, regarding Individual #153, the MOSES performed 4/5/17 was not reviewed by the prescriber until 5/11/17. The prescriber did not review the AIMS assessments regarding Individual #153 dated 12/13/16 and 4/1/17. In another example regarding Individual #179, the prescriber did not review the AIMS assessments dated 11/21/17 and 5/12/17.

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.											
Summary:			Individuals:								
#	Indicator	Overall Score									
37	Emergency/urgent and follow-up/interim clinics were available if needed.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
38	If an emergency/urgent or follow-up/interim clinic was requested, did it occur?										
39	Was documentation created for the emergency/urgent or follow-up/interim clinic that contained relevant information?										
Comments:											

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.											
Summary: Overall, criteria were met, with the exception of two individual's PBSP timeliness. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	N/A	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% 8/8	1/1	N/A	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.	75% 6/8	0/1	N/A	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. Two individuals, Individual #179 and Individual #30, were prescribed psychotropic medication but did not have a current positive behavior support plan or psychiatric support plan in place.											

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: Management of polypharmacy was a strength of the El Paso SSLC. With sustained high performance, indicator 44 might be moved to the category of requiring less oversight after the next review. Indicators 44 and 45 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 4/4	N/A	N/A	N/A	N/A	1/1	N/A	1/1	1/1	1/1
45	There is a tapering plan, or rationale for why not.	75% 3/4	N/A	N/A	N/A	N/A	1/1	N/A	1/1	0/1	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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 44. These indicators applied to four individuals. Polypharmacy justification was appropriately documented in all four examples. The psychiatrist did an excellent job of documenting and reviewing the justification for polypharmacy. 45. There was documentation for three of the four individuals showing a plan to taper various psychotropic medications or documentation of why this was not being considered. 46. When reviewing the polypharmacy committee meeting minutes, there was documentation of committee review for three individuals in the review group meeting criteria for polypharmacy. One individual, Individual #30, met criteria for polypharmacy as of September 2017. Although Individual #30 was added to the list of individuals requiring review by the committee, the review had not yet occurred. The polypharmacy committee meeting was observed during the visit. This meeting was well run and comprehensive.										

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 individual had data that could be used for determining progress according to the criteria for this indicator (3), but the objective and the data collection did not line up correctly. For individuals who the Center described as not progressing, actions were developed for four of the six, and implemented for those four. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
6	The individual is making expected progress	14% 1/7	0/1	1/1	N/A	0/1	0/1	0/1	N/A	0/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	0/1	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.	67% 4/6	0/1	N/A	N/A	1/1	1/1	1/1	N/A	1/1	0/1
9	Activity and/or revisions to treatment were implemented.	100% 4/4	N/A	N/A	N/A	1/1	1/1	1/1	N/A	1/1	N/A

Comments:

6. Individual #63's data were demonstrated to be reliable (see indicator 5) and he was making progress. Individual #192, Individual #104, Individual #26, Individual #159, and Individual #153 were not making progress. Individual #179 was progressing, however, he was scored as 0 because his data were not demonstrated to be reliable (see indicator 5).

7. Individual #63 scored as 0 because progress toward objectives cannot be evaluated (see indicator 3).

8. Individual #192, Individual #104, Individual #26, and Individual #159 were not making expected progress, however, their progress notes included actions to address the absence of progress. Individual #153's October 2017 progress note indicated he had 17 restraints, however, his progress note did not indicate any action to address the increase in restraints. Individual #63 was scored as 0 because progress toward his objectives cannot be evaluated (see indicator 3).

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

Summary: Just less than half of the individuals had most of their staff trained on their PBSPs. This was an improvement from the 0% scores on the previous three reviews. Similarly, PBSP summaries were available and certified behavior analysts oversaw PBSP development. As a result indicators 17 and 18 improved to 100%. All three indicators met criteria for three individuals. All three indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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.	43% 3/7	0/1	0/1	N/A	0/1	0/1	1/1	N/A	1/1	1/1
17	There was a PBSP summary for float staff.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
18	The individual's functional assessment and PBSP were written by a	100%	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1

	BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	7/7									

Comments:
16. Individual #159, Individual #153, and Individual #26 had documentation that at least 80% of 1st and 2nd shift direct support professionals (DSPs) implementing their PBSPs were trained on its implementation. This represents an improvement over the last review when none of the individual's had documentation that their staff were trained on their PBSP. The behavioral health services department staff are encouraged continue to focus on staff training of the PBSP, and ensure that all DSPs are trained on the implementation of PBSPs.

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

Summary: Progress notes needed to improve by being done every month and by including the graphs of PBSP target and replacement behaviors that were being made each month anyway. Data were presented in various meetings and follow-up occurred as per peer review requirements. Thus, with sustained high performance, indicators 21 and 22 might be moved to the category of less oversight after the next review. The frequency/regularly of internal and external peer review needs to be improved. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
19	The individual's progress note comments on the progress of the individual.	14% 1/7	0/1	0/1	N/A	1/1	0/1	0/1	N/A	0/1	0/1
20	The graphs are useful for making data based treatment decisions.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	1/1	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 peer review occurred at least five times, for a total of at least five different individuals, in the past six months.	0%									

Comments:
19. All individuals had progress notes, however, this indicator was scored as 0 for all individuals other than Individual #192 because they had three or less progress notes in the last six months.

20. All individuals had graphed PBSP data that were useful for making data based decisions. The graphs, however, were not located in the progress notes. In order to be most useful, current graphs should be in each individual's progress note.

21. In order to score this indicator, the Monitoring Team observed Individual #153 and Individual #179's psychiatric clinic meetings. In both meetings, the Monitoring Team found that current data were presented and graphed, which encouraged data based decisions by the team.

22. Individual #104's peer review minutes were used score this indicator. The minutes from his 8/25/17 peer review suggested plans that would contribute to reductions in his behavioral targets. There was evidence of follow-up/implementation of those recommendations in his October 2017 peer review meeting.

23. In order for this indicator to be scored as complete, there needs to be documentation that internal peer occurred at least three times a month for each of the last six months, and that external peer review occurs in at least five of the last six months. El Paso SSLC had documentation that external peer review meetings occurred in three of the last 6 months. Additionally, internal peer review only occurred twice in the month of July 2017.

Outcome 8 – Data are collected correctly and reliably.

Summary: El Paso SSLC's data collection systems adequately measured target and replacement behaviors and the Center set treatment and data integrity measures and goals. This has been the case for four reviews, including the change over to the electronic health record. Therefore, four indicators (26, 27, 28, 29) will be moved to the category of requiring less oversight. These data collection targets, however, were not being met, therefore, indicator 30 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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	N/A	1/1	1/1
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).	100% 7/7	1/1	1/1	N/A	1/1	1/1	1/1	N/A	1/1	1/1
30	If the individual has a PBSP, goal frequencies and levels are achieved.	14% 1/7	0/1	0/1	N/A	0/1	0/1	0/1	N/A	1/1	0/1

Comments:
26-27. 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 #159.
- Individual #179 did not have DCT assessments conducted in the last six months. Individual #63 did not have IOA assessments conducted in the last six months.
- Individual #192 and Individual #104 had IOA, DCT, and treatment integrity scores collected during the last six months that were above 80%, however, their treatment integrity was scored 0 because their October 2017 progress notes indicated that their PBSPs were not being implemented with integrity.
- Individual #26 and Individual #153 also had IOA, DCT, and treatment integrity scores collected during the last six month that were above 80%, however, their IOA was scored 0 because the reliability of their PBSP data was questionable (see indicator 5). 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.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
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 #192 – GI problems, and neurological; Individual #104 – other: hyperprolactinemia, and other: hypothyroidism; Individual #90 – other: hyperlipidemia, and osteoporosis; Individual #103 – respiratory compromise, and constipation/bowel obstruction; Individual #82 – seizures, and osteoporosis; Individual #99 – cardiac disease, and diabetes; Individual #4 – other: kidney stones, and constipation/bowel

obstruction; Individual #25 – GI problems, and other: anemia; and Individual #102 – other: deep vein thrombosis, and seizures).

None of the goals/objectives were clinically relevant, achievable, and/or measurable.

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

Outcome 4 – Individuals receive preventative care.

Summary: Of significant concern, none of the nine individuals reviewed received the preventative care they needed. In addition, the Center needs to focus on ensuring medical practitioners review and address, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
a.	Individual receives timely preventative care:										
	i. Immunizations	56% 5/9	1/1	1/1	1/1	0/1	1/1	0/1	0/1	0/1	1/1
	ii. Colorectal cancer screening	75% 6/8	0/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	0/1
	iii. Breast cancer screening	0% 0/1	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A	N/A
	iv. Vision screen	56% 5/9	0/1	0/1	1/1	0/1	0/1	1/1	1/1	1/1	1/1
	v. Hearing screen	11% 1/9	0/1	0/1	1/1	0/1	0/1	0/1	0/1	0/1	0/1
	vi. Osteoporosis	38% 3/8	N/A	0/1	0/1	1/1	0/1	0/1	1/1	1/1	0/1
	vii. Cervical cancer screening	100% 1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

	as well as endocrine risks, as applicable.										

Comments: a. The following problems were noted:

- For Individual #192, no vision or hearing screenings were submitted. He had a recommendation from GI to have a c-scope due to bloody stools. The Medical Director cancelled it.
- Individual #104's last vision screening was dated 5/9/14. The date of his last hearing screening is unknown, but the AMA stated it should be repeated every three years. On 11/2/11, his last DEXA scan was normal. However, he has hyperprolactinemia, which increases risk for osteoporosis, and it was unclear how long he had hyperprolactinemia.
- On 5/19/15, Individual #90's DEXA scan showed osteoporosis. It should have been repeated in two years.
- Individual #103's varicella status could not be determined based on the immunization records. The Center submitted an ultrasound of the left breast to guide a biopsy, but did not submit a mammogram report. Her last annual vision exam was on 4/5/16. Her last hearing screening was in 2013, and the audiologist recommended removing the individual from audio testing. This is inconsistent with the annual screening guidelines/regulations.
- On 5/26/15, Individual #82's DEXA scan showed osteopenia of the left hip. There was no plan for this, and no repeat DEXA in 2017. His last annual eye exam was on 2/16/16. Given he is prescribed Topamax, annual glaucoma screening is important. On 1/27/10, he had his last hearing screening with a recommendation for removal from further audiological testing, which again was inconsistent with current guidelines/regulations.
- Individual #99's varicella status could not be determined based on the immunization records. The DEXA results, dated 2/10/17, showed osteopenia to the left hip, but no FRAX score had been calculated. Similar issues as discussed above were noted with regard to his hearing screening.
- Individual #4 also had not had an annual hearing screening. His varicella status could not be determined based on the immunization records.
- For Individual #25, her varicella and zoster status could not be determined based on the immunization records. The same concern was noted with regard to the lack of a hearing screening.
- Individual #102 had not had hearing testing since 2013. His last vision exam was completed on 3/7/16, and the PCP had not requested any specific monitoring for intraocular pressure (IOP). On 1/26/16, the DEXA scan showed osteopenia of the left hip. No FRAX score was calculated to determine if pharmacologic therapy was indicated. The AMA noted colon polyps in 2009, and in 2014, a repeat colonoscopy was done and a polyp was removed. There was no documentation of the pathology of the polyp and the frequency of surveillance.

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. The more recent AMAs included a risk section, but these sections generally just included information that was cut and pasted from the QDRR with no comment from the PCP.

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									
Comments: a. None of the individuals that the Monitoring Team responsible for the review of physical health reviewed had DNR Orders in place at the time of the monitoring visit.											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: Significant problems continued to be noted with regard to the quality of PCPs' assessment of acute issues, provision of timely treatment and/or interventions for the acute illness, as well as PCPs' follow-up to acute illnesses and occurrences. In addition, IDTs, including the PCP, need to focus on holding post-hospital ISPA meetings to addresses follow-up medical and healthcare supports to reduce risks and promote early recognition, as appropriate. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
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.	33% 3/9	0/1	0/2	N/A	2/2	0/1	0/2	1/1	N/A	N/A
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	33% 3/9	0/1	0/2		1/2	1/1	0/2	1/1		
c.	If the individual requires hospitalization, an ED visit, or an Infirmary admission, then, the individual receives timely evaluation by the PCP or a provider prior to the transfer, 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.	64% 7/11	0/1	0/1	1/2	N/A	N/A	2/2	1/2	1/1	2/2

d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	57% 4/7	0/1	0/1	0/1			1/1	N/A	1/1	2/2
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.	36% 4/11	0/1	0/1	0/2			1/2	1/2	1/1	1/2
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance with this indicator, it has 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.	43% 3/7	N/A	1/1	0/2			1/2	1/1	N/A	0/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.	18% 2/11	0/1	0/1	0/2			0/2	1/2	0/1	1/2

Comments: a. For six of the nine individuals reviewed, the Monitoring Team reviewed nine acute illnesses addressed at the Center, including: Individual #192 [upper respiratory infection (URI) on 9/17/17], Individual #104 (foreign body ingestion on 11/19/17, and human bite on 6/30/17), Individual #103 (acute conjunctivitis on 7/21/17, and bronchitis on 9/5/17), Individual #82 (atopic dermatitis on 8/10/17), Individual #99 (foul smelling urine on 8/24/17, and constipation/dehydration on 8/30/17); and Individual #4 (allergic rhinitis/cerumen impaction on 9/8/17).

PCPs assessed the following acute issues according to accepted clinical practice: Individual #103 (acute conjunctivitis on 7/21/17, and bronchitis on 9/5/17), and Individual #4 (allergic rhinitis/cerumen impaction on 9/8/17).

b. For Individual #103 (acute conjunctivitis on 7/21/17), Individual #82 (atopic dermatitis on 8/10/17), and Individual #4 (allergic rhinitis/cerumen impaction on 9/8/17), the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolved or stabilized.

The following provide examples of concerns noted:

- On 9/17/17 at approximately 10:00 a.m., nursing staff documented that Individual #192 had a dry cough and clear nasal drainage. He was "placed on the clinic list for further evaluation." On 9/18/17, the PCP evaluated the individual for nasal congestion and cough. It was not clear why the assessment was delayed 24 hours. The diagnosis was acute nasopharyngitis. The plan was "will treat symptoms; follow-up as needed." The PCP did not specify the treatment that would be provided. On 9/25/17, nursing documented a large amount of emesis. Given the individual's risk for respiratory infection, the PCP should have conducted and documented follow-up through to resolution.
- On 9/22/17, the PCP documented that on 9/19/17, Individual #104 ate pieces of a non-toxic foam ball. Reportedly, the individual initially refused assessment. The physical exam was noted to be normal and a KUB (i.e., abdominal x-ray) was ordered. The PCP did not document any follow-up assessment or report of the KUB. The next PCP entry was on 10/30/17, and

it was related to a groin rash.

- On 6/30/17, Individual #104 sustained a superficial human bite to the left wrist. On 7/3/17, the PCP documented that she received a call on 6/30/17, regarding a human bite, and she prescribed Augmentin. The 7/3/17 assessment noted a 2.5 centimeter (cm) by 3 cm oval healing laceration with no signs of infection. The plan was to continue antibiotics. An IPN addendum noted that the human bite protocol was initiated. However, no explanation was included of the actions this protocol requires or which actions staff actually took. The next note, dated 7/7/17, stated: "assault by human bite resolving; follow-up as needed." The records did not include any documentation that this issue was referred to Infection Control or that the appropriate actions were taken for a human bite. Per the Centers for Disease Control (CDC) guidelines for human bites, the clinical evaluation must include the possibility that both the person bitten and the person who inflicted the bite were exposed to blood-borne pathogens.
- On 8/24/17, the PCP wrote that nursing staff reported that Individual #99 had foul smelling urine. The plan was to obtain a urinalysis. However, the PCP documented no follow-up or results of a urinalysis.

  On 8/28/17, nursing staff documented that the individual had increasingly aggressive behavior. An emergency IDT meeting was held, but there was no documentation of a medical assessment. On 8/30/17, the PCP evaluated the individual due to no bowel movement in three days. Labs were obtained and the results were consistent with dehydration. On 8/30/17, at 11:39 p.m. (after the other PCP documented dehydration), the PCP, who requested the urinalysis on 8/24/17, documented that attempts to obtain a urinalysis were not successful.

  With regard to lack of a bowel movement in three days, Individual #99 responded to a dose of magnesium citrate that was given the previous night. To address the dehydration, the plan was to "push 2 liters of fluids" and check a comprehensive metabolic panel (CMP) in two days. There was no documentation of a repeat CMP in two days. On 9/7/17, follow-up occurred for "dehydration and staff reporting low blood pressure." The PCP noted that there was a single episode of hypotension with a blood pressure reading of 88/57. A CMP and complete blood count (CBC) done on 9/7/17 were normal.

c. For seven of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses/occurrences that required hospitalization or an ED visit, including those for Individual #192 (foreign body ingestion on 10/10/17), Individual #104 (foreign body removal on 11/8/17), Individual #90 (pneumonia on 8/16/17, and pneumonia on 8/22/17), Individual #82 (weight loss on 7/27/17, and hypotension on 10/13/17), Individual #4 (aspiration pneumonia on 7/20/17, and renal hematoma on 8/7/17), Individual #25 [URI/urinary tract infection (UTI) on 9/12/17], and Individual #102 (UTI/hypernatremia on 11/8/17, and UTI/nephrolithiasis on 11/14/17).

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

- On 10/9/17, Individual #192's PCP documented an after-hours call on 10/8/17, regarding the ingestion of a piece of glass. On 10/9/17, the exam was unremarkable and the plan was to check a KUB. The PCP did not document a follow-up assessment or the results of the KUB.

  On 10/12/17 at approximately 10:00 a.m., the individual was transferred to the ED, and the PCP documented in the IPN that the reason was that the Center's KUB showed a small foreign body in the cecum. The ED records were not available to the PCP,

but the plan was to check periodic KUBs. No documentation was submitted to show that the PCP followed up with periodic KUBs. More specifically, on 10/19/17, nursing staff documented complaints of right should pain and Individual #192 was referred to clinic. There was no documentation of a medical assessment. On 10/23/17, nursing staff documented two attempts to contact the PCP to report a medication refusal, but there was no response from the PCP. The next PCP assessment was on 10/24/17, and it was related to complaints of cough and congestion. Follow-up for this issue occurred on 10/26/17.

- On 11/1/17, nursing staff documented that Individual #104 had bloody stools. On 11/1/17, nursing staff also documented that the individual had a dark stool and a glove was found in the stool. The PCP did not document an assessment. However, on 11/3/17, the PCP documented that the individual was "scheduled for CT [computed tomography] scan of abdomen and pelvis today" due to pica.

  On 11/8/17, nursing staff documented that the individual was being transferred to the ED due to a 10 to 15 cm mass in the duodenum seen on the CT done five days earlier (11/3/17). The PCP did not provide any related documentation. On 11/8/17, Individual #104 was admitted to hospital, and discharged on 11/13/17. A foreign body (i.e., a black bowed plastic tube) was removed by esophagogastroduodenoscopy EGD. On 11/15/17, the PCP wrote a note about follow-up for a groin rash. It did not discuss the hospitalization for the foreign body removal. On 11/16/17, the PCP wrote that the individual had a foreign body removed on 11/13/17, and the only plan was to return to the clinic as needed.
- On 8/16/17, nursing staff documented that at approximately 8:00 a.m., Individual #90 was clammy and diaphoretic with an elevated heart rate and oxygen saturation of 88%. At approximately 8:40 a.m., he was transferred to the ED and was admitted with the diagnosis of pneumonia. The transfer occurred during normal business hours, but a medical provider did not document an evaluation prior to transfer, nor did the PCP write a note as required. On 8/20/17 at approximately 7:00 p.m., Individual #90 returned to the Center with a diagnosis of pneumonia.

  On 8/21/17, nursing staff documented that the "individual is diaphoretic, tense and alert." Multiple attempts were made to contact two primary care providers. The individual continued to deteriorate with his respiratory rate and pulse increasing and oxygen saturation decreasing. Nursing staff activated emergency medical services (EMS) for an emergent transfer. The PCP returned the nurses' call approximately one hour after the 911 call and was notified of the transfer. The PCP wrote a note within one business day.

  Individual #90 was evaluated in the ED, and on 8/22/17 at 9:40 a.m., returned to the Center. The PCP evaluated the individual noting dyspnea was attributed to agitation. Adult failure to thrive was the diagnosis and the plan was to obtain a chest x-ray in two days and follow up in three days. Follow-up also should have occurred on the 8/23/17, but did not.

  On 8/24/17, the PCP evaluated Individual #90 again due to diaphoresis, an oxygen saturation of 77%, and anxiety. The individual was documented to be angry and anxious with mild diaphoresis. The chest x-ray showed a worsening right lower lobe infiltrate. The plan was to repeat the chest x-ray in three days, check labs in the morning, and continue oxygen. On 8/25/17, the PCP documented that the individual was improved and was off of the oxygen. The plan was to follow-up in one week.

  On 9/1/17, another PCP documented that the chest x-ray, done on 8/31/17, showed opacities consistent with aspiration or an

evolving multifocal pneumonia. The exam recorded a respiration rate of 22 and oxygen saturation of 94%. Levaquin was started with a plan to follow up in one week. Again on 9/5/17, Individual #90 was seen due to an episode of tachypnea. There was no change in the plan. From 9/8/17 to 9/15/17, he was admitted to the hospital again for aspiration pneumonia, and again on 9/25/17. He died during this final hospitalization.

- On 10/12/17, Individual #99's PCP documented: "Nurse in charge of client called at approximately 0130 reporting patient had temp of 101 and was given Tylenol; It was further reported POX 89% on room air. Asked patient be placed on O2 at 2 liters and monitor." Labs were ordered, and at 8:00 a.m., the PCP evaluated the patient. At that time, Individual #99's blood pressure was 101/56, respiration rate was 22, and oxygen saturation was 91%. Reported, his white blood cell count (WBC) was 11.8, and the CMP was normal. Atelectasis was noted on the chest x-ray. The assessment was atelectasis secondary to asthma. The plan was to discuss a steroid increase with Internal Medicine (IM) consultant that afternoon. There was no documentation that the Advanced Practice Nurse Practitioner (APRN) discussed the plan with a physician. The individual was transferred to the ED for evaluation around 11:46 p.m. for evaluation of hypotension, diaphoresis, and tachycardia. On 10/13/17, at approximately 5:40 a.m., Individual #99 returned to the Center.

  On 10/13/17 at 3:52 p.m., the IM consultant documented a post-ED assessment. The consultant noted that the individual was seen for poor oral intake with hypotension and a slightly elevated WBC count. The plan was to monitor the individual closely, give additional intravenous (IV) fluids, and check a urinalysis. There was no documentation of further physician follow-up for this individual who was given IV fluid boluses and who had a mild leukocytosis. The next PCP note was on 10/20/17, for an assessment of an abrasion to the left shoulder
- From 8/1/17 to 8/4/17, Individual #4 was admitted to the hospital for a right nephrolithotomy. On 8/4/17, the PCP saw him, and noted he had a low-grade temperature of 99.4. The plan was to check labs and follow-up on 8/7/17. This individual had an invasive surgical procedure and developed a low-grade temperature post-operatively. A medical plan to conduct follow-up 72 hours later was not clinically appropriate. On 8/7/17, Individual #4 was referred back to the ED due to a gross hematuria.

  On 8/8/17, the PCP wrote a note summarizing the recent medical events (the dates were not consistent with other documentation in the records). The etiology of the gross hematuria was a pericapsular hematoma associated with the nephrolithotomy procedure. Of note, on 8/7/17, the renal ultrasound showed "re-demonstration of 3.6cm left upper pole mass suspicious for renal cell carcinoma." The PCP provided no additional documentation.

  On 8/13/17, Individual #4 was sent back to the hospital for evaluation of a fever. He was admitted with severe sepsis without septic shock secondary to bilateral healthcare associated pneumonia and acute kidney failure with tubular necrosis.

  On 8/16/17, the PCP wrote a note detailing further assessment of the kidney mass that was evaluated with CT (mass may correspond with previous history of renal cell carcinoma). There was no additional follow-up for this hospitalization. The next PCP evaluation was on 9/8/17, related to upper respiratory congestion.
- On 9/12/17, Individual #25 was seen for evaluation of cough, nasal congestion, and emesis. She was noted to have bradycardia and hypoxemia while sleeping. She was referred to the ED for evaluation. On 9/13/17, she returned to the Center with diagnoses of URI, and UTI. The urinalysis showed three to five WBCs per high power field (HPF). The results of the urine culture were pending.

On 9/13/17, the PCP saw her again and noted she was improving. On 9/15/17, the PCP documented a note for an evaluation done on 9/14/17. The urine culture was documented to have greater than 100 thousand colonies. A decision was made to repeat the urinalysis with culture and sensitivity. On 10/31/17, the PCP documented that the urinalysis showed 15 to 20 WBCs, and the plan was to recheck the urinalysis. There was no follow-up urinalysis documented.

- On 10/31/17, the PCP documented that Individual #102 was evaluated due to the report of foul smelling urine and penile redness. A urinalysis was ordered. On 11/6/17, the PCP documented that the urinalysis was within normal limits, and the penile abrasion had resolved. However, the urinalysis was not normal, as it had three to five WBC/HPF. The subsequent urine culture grew extended spectrum beta-lactamases (ESBL) E. coli. On 11/7/17, the PCP documented that nitrofurantoin would be started. This represented a seven-day period between initial assessment and treatment.

  On 11/8/17, the PCP transferred the individual to the ED due to a temp of 102.5, increased respirations, and hypoxia. He was admitted to the hospital with the diagnoses of UTI and hypernatremia. On 11/13/17, he returned to the Center, and on 11/14/17, the PCP saw him. The IPN entry, written around 7:00 p.m., indicated that Individual #102 was shaking and shivering upon assessment and was sent back to the hospital at around 2:46 p.m., for evaluation of hypotension, tachypnea, and bradycardia. He was admitted to the hospital with the diagnoses of UTI and bilateral kidney stones. He underwent multiple procedures for stone removal. On 11/17/17, he returned to the Center. Per the PCP, additional treatment was needed for the management of the ureteral stones. The PCP documented no additional follow-up for this hospitalization.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: As has been the finding for the last several reviews, the Center needs to focus on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs. Indicator e will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
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% 0/3	0/1	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed included those for Individual #192 for podiatry on 11/30/17, and gastroenterology (GI) on 6/15/17; Individual #104 for neurology on 8/1/17; Individual #90 for endocrinology, and GI on 6/14/17; Individual #103 for breast clinic on 11/15/17, and GI on 9/20/17; Individual #82 for neurology on 6/6/17; Individual #99 for pulmonology on 9/22/17, and cardiology on 11/8/17; Individual #4 for urology on 9/6/17, and GI on 9/29/17; Individual #25 for neurology on 11/21/17, and neurology on 9/19/17; and Individual #102 for neurology on 8/1/17.

e. For Individual #192 for GI on 6/15/17, the PCP did not make a referral to the IDT to ensure proper supports were in place for the necessary bowel preparation, which ultimately failed.

For Individual #99 for cardiology on 11/8/17, the request was for "evaluation; Tachycardia." The cardiologist noted "Hx [history]of tachycardia; EKG [electrocardiogram] Reviewed, NSR [normal sinus rhythm]. Unable to obtain much Hx. due to MR [mental retardation]. Tachycardia is probably sinus and physiologic." The recommendation was to obtain a Holter, echo, and thyroid stimulating hormone (TSH) level. The PCP disagreed with the recommendations of the cardiologist, noting "no further workup is needed. He will be followed by Internal Medicine here in the facility." The IDT should have been made aware of the disagreement and decision to not follow the recommendations of the cardiologist.

For Individual #4 for urology on 9/6/17, the PCP did not make a referral to the IDT. The IPN note stated that a repeat surgery was being scheduled. The IDT should have been informed of this, and discussed follow-up care.

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

Summary: Significant work is needed to ensure 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	192	104	90	103	82	99	4	25	102
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.	28% 5/18	0/2	1/2	0/2	1/2	0/2	0/2	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 #192 – GI problems, and neurological; Individual #104 – other: hyperprolactinemia, and other: hypothyroidism; Individual #90 – other: hyperlipidemia, and osteoporosis; Individual #103 – respiratory compromise, and constipation/bowel obstruction; Individual #82 – seizures, and osteoporosis; Individual #99 – cardiac disease, and diabetes; Individual #4 – other: kidney stones, and constipation/bowel obstruction; Individual #25 – GI problems, and other: anemia; and Individual #102 – other: deep vein thrombosis, and seizures).

a. For the following individuals' chronic or at-risk conditions, medical assessment, tests, and evaluations consistent with current standards of care were completed, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #104 – other: hypothyroidism; Individual #103 – constipation/bowel obstruction; Individual #4 –constipation/bowel obstruction; Individual #25 – GI problems; and Individual #102 – other: deep vein thrombosis. The following provide examples of concerns noted:

- For Individual #192, the PCP did not discuss constipation in the AMA, and no interim medical reviews were submitted. According to the IRRF, he was rated at medium risk for emesis, but low risk for constipation and GERD. However, the individual received treatment for constipation with MiraLax and docusate. He also had bloody stools documented and was referred to gastroenterology (GI) and scheduled for a colonoscopy. The PCP canceled it, stating the bloody stools were due to hemorrhoids and constipation. Therefore, a low risk for constipation did not appear appropriate, but the IDT did not re-rate him.
- In addition, on 7/19/17, Individual #192 had a CT of the head without contrast that showed a partial empty sella turcica (i.e., the place where the pituitary gland sits). The PCP did not document any plan to address the tremors, falls, and CT scan. There should be further investigation to determine the etiology of the partially empty sella.
- For Individual #104, for the diagnosis of hyperprolactinemia, the AMA assessment/plan was to continue bromocriptine. The PCP noted that individual's prolactin level was 64.4 on 11/11/16, and the PCP indicated the plan was to follow-up with psychiatry. The treatment with bromocriptine was appropriate, but the monitoring for hyperprolactinemia was not consistent with current guidelines. For example, the AMA did not address other issues related to hyperprolactinemia, such as the hypogonadism, osteoporosis, etc. The physical exam noted normal breasts, but did not address if galactorrhea was present (i.e., discharge expressed from the nipples). Interestingly, the ultrasound done in 2016 documented gynecomastia.
- For Individual #90's hyperlipidemia, the plan in the AMA was to continue simvastatin. The last lipids documented were done on 7/15/16. The indication for treatment was not documented. Based on current American College of Cardiology/American Heart Association (ACC/AHA) guidelines, a risk score should have been calculated if treatment was for primary prevention and a decision should have been made regarding statin intensity. The Clinical Pharmacist commented in the two most recent QDRRs that a moderate-intensity statin was indicated. The individual received a low-intensity statin. The AMA plan did not document how follow-up would be conducted.
- For Individual #82, the AMA assessment/plan section noted that the individual was on topiramate for control of his seizure disorder. The last seizure was in 2011. However, the PCP did not justify the need for continued anti-epileptic drug (AED) therapy in this individual who has been seizure free for six years.
- Individual #82's DEXA scan, completed on 5/26/15, showed osteopenia of the left hip. The AMA did not list osteopenia of the hip as an active problem; therefore, there was no assessment and plan to address it. No repeat study was done in May 2017. Individual #82 had a Vitamin D deficiency. Given the lack of a FRAX score, it is not clear that the individual is receiving adequate treatment for osteopenia of the hip.
- For Individual #99, the PCP did not address the abnormal lipids that were documented in the AMA. Moreover, there was no discussion of the atherosclerotic cardiovascular disease (ASCVD) risk score. On 6/16/17, the Clinical Pharmacist documented a 6.8% risk score, and on 9/15/17, a 9.1% risk score. On 6/29/17, the PCP documented the lipid results noting that there was no indication for statin therapy. This determination did not include a discussion of the ACC/AHA 2013 guidelines related to primary prevention based on risk score. The most recent score of 9.1, as calculated by the Clinical Pharmacist, is an indication

for statin therapy.

- According to Individual #99's AMA, his hemoglobin (Hgb) A1c improved from 5.9 to 5.4. The plan was to monitor his nutritional status, weight, and continue physical activity. His interim review reiterated this information. Neither of these assessments specified the diet, weight status, or how physical activity would be increased.
- According to Individual #4's AMA, he required follow-up with urology for the diagnosis of kidney stones. The PCP documented that neurology was aware of kidney stones, as Zonisamide can cause stone formation. However, the neurology consult, done on 6/19/17, did not document the presence of kidney stones. It noted that urology was evaluating the individual for a left kidney mass. Moreover, the PCP did not document any information related to stone analysis or interventions to decrease/minimize recurrent stone formation. This individual had multiple recurrent stones, including a staghorm calculus.
- Individual #25's AMA did not specify the etiology of the macrocytic anemia. For example, it did not indicate whether it was medication-related or due to a deficiency. There was no explanation of why the individual required treatment with iron supplementation (e.g., a history of iron deficiency or blood loss). A source of iron deficiency must always be identified.
- According to Individual #102's AMA, he was prescribed Topiramate and Keppra. The last seizure was in 2015. The plan was to continue medications and follow up with neurology as scheduled. The AMA plan did not provide any evidence of the necessary monitoring for an individual who is treated with Topiramate, including monitoring for adverse effects such as metabolic acidosis, renal stone formation, and glaucoma.

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

Summary: Overall, IHCPs did not include a full set of action steps to address individuals' medical needs. For less than 50 percent of the plans reviewed, documentation was found to show implementation of those action steps assigned to the PCPs that IDTs had included 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.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	44% 8/18	0/2	1/2	0/2	2/2	1/2	1/2	1/2	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. The action steps assigned to the PCPs that were identified for the individuals reviewed that were implemented were for: Individual #104 – other: hypothyroidism; Individual #103 – respiratory compromise, and constipation/bowel obstruction; Individual #82 – seizures; Individual #99 – diabetes; Individual #4 – constipation/bowel obstruction; Individual #25 – GI problems; and Individual #102 – other: deep vein thrombosis.

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: It was good to see that the Pharmacy Department reviewed the new orders selected for review, and notified the prescribing practitioner when an intervention was necessary. This is the first time the Monitoring Team has reviewed these indicators at EPSSLC. They will remain in active oversight.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	100% 17/17	2/2	2/2	2/2	2/2	1/1	2/2	2/2	2/2	2/2
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	100% 4/4	1/1	N/A	1/1	1/1	N/A	N/A	1/1	N/A	N/A

Comments: a. and b. The Monitoring Team selected two new medications for each individual reviewed, including divalproex on 6/27/17, and ergocalciferol on 8/18/17 for Individual #192; Bromocriptine, and lorazepam on 11/8/17 for Individual #104; Clindamycin on 8/1/17, and Levofloxin on 9/1/17 for Individual #90; Tylenol on 11/1/17, and Calcium/Vitamin D on 10/19/17 for Individual #103; cetirizine on 8/10/17 for Individual 82 (only one new medication was introduced); docusate on 12/6/17, and trihexyphenidyl on 11/2/17 for Individual #99; cefuroxime on 8/16/17, and cetirizine on 9/9/17 for Individual #4; clobazam on 11/21/17, and lactulose on 10/23/17 for Individual #25; and Nitrfurantoin on 11/17/17, and Calcium/Vitamin D on 10/17/17.

It was good to see that the Pharmacy Department reviewed these new orders, and notified the prescribing practitioner when an intervention was necessary.

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: Since the last review, improvement was noted with regard to the Clinical Pharmacist's review of laboratory results, and the inclusion of recommendations in QDRRs, as appropriate. It was positive that the PCPs responded to the Pharmacist's recommendations in QDRRs, as well as to interventions related to new medication orders. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 192	104	90	103	82	99	4	25	102
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance with this indicator, it has									

		moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	78% 14/18	2/2	2/2	0/2	2/2	0/2	2/2	2/2	2/2	2/2
	ii. Benzodiazepine use;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iii. Medication polypharmacy;	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
	iv. New generation antipsychotic use; and	100% 3/3	2/2	N/A	N/A	N/A	N/A	1/1	N/A	N/A	N/A
	v. Anticholinergic burden.	100% 18/18	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2	2/2
c.	The PCP and/or psychiatrist document agreement/disagreement with the recommendations of the pharmacist with clinical justification for disagreement:	Due to the Center's sustained performance with these indicators, they have moved to the category requiring less oversight.									
	i. The PCP reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
	ii. When the individual receives psychotropic medications, the psychiatrist reviews and signs QDRRs within 28 days, or sooner depending on clinical need.										
d.	Records document that prescribers implement the recommendations agreed upon from QDRRs.	100% 12/12	2/2	1/1	1/1	2/2	1/1	2/2	N/A	1/1	2/2
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.	100% 2/2	N/A	N/A	N/A	1/1	N/A	N/A	1/1	N/A	N/A
Comments: b. For Individual #82, the May 2015 bone mineral density (BMD) test showed osteopenia of the left hip. The Clinical Pharmacist did not recommend completion of a two-year repeat test. In its comments on the draft report, the State disputed this finding, and stated: "From the national osteoporosis guidelines BMD monitoring is recommended every 1 to 2 years after initiating medical therapy for osteoporosis. This is implemented by use of the local laboratory matrix (Refer to document TX-EP-1801-I.O). Individual is not on medical therapy for osteoporosis and therefore recommending a BMD would not be within the scope of pharmacy practice but rather a medical preventative care measure (Medical: outcome 4, indicator a.vi.)." However, as noted in the medical section of the draft report, the DEXA, completed on 5/26/15, showed osteopenia of the left hip. The decision to initiate medical therapy for osteopenia of the hip is not based entirely on a BMD score. The FRAX score should have been calculated. Based on the FRAX score a decision is made regarding treatment. Given the lack of a FRAX score, it was not clear that the individual was receiving adequate										

treatment for osteoporosis. The individual had a diagnosis of osteopenia of the hip and vitamin D deficiency for which the he received vitamin D supplementation. It is, therefore, reasonable to expect the Clinical Pharmacist to note the need for a FRAX score to help further guide therapy. Additionally, the Center should determine if the local laboratory matrix continues to be a valid tool. State Office has informed the Monitoring Team that the local lab matrix is obsolete. The Medical Department should have implemented clinical guidelines to provide guidance on the diagnosis and treatment of osteoporosis.

For Individual #90, in the QDRRs, the ASCVD risk score was calculated as 8.6% and 9.8%, which was an indication for moderate to high intensity statin therapy. The Clinical Pharmacist did not make a formal recommendation for this, but noted the individual was on a low intensity statin regimen.

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

e. On 11/1/17, the PCP wrote an order for oral administration of Tylenol, but Individual #103 receives all medications through her gastrostomy tube (G-tube). Based on the Pharmacy's intervention, the PCP corrected this medication variance.

For Individual #4, on 8/16/17, the PCP wrote an order for cefuroxime, and it did not include a stop date. In response to the intervention, the PCP clarified this was the result of a post-hospital assessment that the Nurse Practitioner completed, and the medication would be prescribed for seven days.

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	192	104	90	103	82	99	4	25	102
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/6	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% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									

Comments: a. and b. Individual #4, Individual #25, and Individual #102 were edentulous, but were part of the core group, so full reviews were conducted. The Monitoring Team reviewed six individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

c. through e. In addition to a lack of clinically relevant, achievable, and measurable goals/objectives, integrated progress reports on existing goals with data and analysis of the data often were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. For all nine individuals, the Monitoring Team conducted full reviews of the processes related to the provisions of dental supports and services.

Outcome 4 – Individuals maintain optimal oral hygiene.											
Summary: N/A			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Since the last exam, the individual's poor oral hygiene improved, or the individual's fair or good oral hygiene score was maintained or improved.	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R

Comments: a. 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 and implemented a process to ensure inter-rater reliability with the Centers.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: A number of individuals reviewed had not had needed dental treatment. Over the past several reviews, this has been a consistent finding. Center staff need to take steps to correct these lapses in care. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If the individual has teeth, individual has prophylactic care at least twice a year, or more frequently based on the individual's oral hygiene needs, unless clinically justified.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1	N/A	N/A	N/A
b.	Twice each year, 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	1/1	0/1	0/1	1/1	0/1			

	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.	20% 1/5	0/1	0/1	0/1	0/1	1/1	N/A			
e.	If the individual has need for restorative work, it is completed in a timely manner.	100% 2/2	1/1	N/A	N/A	N/A	1/1	N/A			
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A			
Comments: a. through f. Individual #4, Individual #25, and Individual #102 were edentulous. A number of individuals reviewed had not had needed dental treatment.											

Outcome 7 – Individuals receive timely, complete emergency dental care.											
Summary: It was good to see that the one individual reviewed who required emergency dental care received it in a timely and complete manner.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
b.	If the dental emergency requires dental treatment, the treatment is provided.	100% 1/1	1/1								
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	100% 1/1	1/1								
Comments: a. through c. On 6/11/17 at approximately 12:07 p.m., nursing staff documented that Individual #192 complained of a tooth ache and refused breakfast as a result. At 11:49 a.m., nursing staff contacted the PCP and the individual was referred to the clinic. The nursing documentation did not include a plan for pain management. On 6/12/17, the PCP documented "will see today." The PCP wrote a note stating the dental hygienist would see the individual. The Tylenol #3 was discontinued, but Tylenol could be administered as needed. On 6/12/17 at approximately 11:30 a.m., the dentist saw Individual #192, and diagnosed tooth #18 with a large carious lesion. The plan was to return to dental clinic for a temporary filling, which was placed on 6/14/17.											

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.	
Summary: At the time of the last review, Indicator b moved to less oversight, but during this review, measurable action steps were not included in IHCPs, and data was not available to show implementation of suction tooth brushing. Therefore, Indicator b will return to active oversight, and the Monitoring Team will continue to	Individuals:

review the remaining indicators. On a positive note, Dental Department staff monitored suction tooth brushing for the individuals reviewed who received it.											
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	0% 0/2	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	Due to the Center's sustained performance with this indicator, at the time of the Round #12 review, it moved to the category requiring less oversight. However, based on information for this review, data was not available to support the completion of suction tooth brushing for the two relevant individuals, so this indicator will return to active monitoring.									
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	100% 2/2			1/1	1/1					
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/2			0/1	0/1					
Comments: a. and b. IHCPs did not include measurable objectives for suction tooth brushing. In addition, the Center did not submit data to show the completion of suction tooth brushing for either Individual #90 or Individual #103. As a result, Indicator b will return to active oversight. c. It was positive that Dental Department staff were monitoring staff's implementation of suction tooth brushing for quality, as well as safety.											

Outcome 9 – Individuals who need them have dentures.											
Summary: Improvements still were needed with regard to the dentist's assessment of the need for dentures for individuals with missing teeth. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	83% 5/6	0/1	N/A	1/1	N/A	N/A	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Comments: a. Individual #192 was missing teeth 8, 9, and 10 (i.e., his front teeth). The Dental Department documented: "no partial/denture recommend by dentist, He has 29 teeth." It was unclear why the dentist would not recommend a partial, since the											

maxillary central incisors are the most visible teeth.

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. This is a substantial deviation from standard practice and needs to be corrected. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	0%									
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.	0%									
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	0%									
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%									
e.	The individual has an acute care plan that meets his/her needs.	0%									
f.	The individual's acute care plan is implemented.	0%									
Comments: a. through f. Based on the Center's response to the Monitoring Team's document request for acute care plans, nurses were not developing and implementing acute care plans for all acute illnesses or occurrences. At least in part, the conversion to the IRIS system complicated entry of acute care plans into the system. However, this is a substantial deviation from standard practice and needs to be corrected. The Monitoring Team discussed this issue with State Office. Given that Center staff acknowledged that acute care plans have not been consistently developed and entered into the system, it was decided that the Monitoring Team would not search for needed acute care plans that might not exist. However, as a result of this systems issue, these indicators do not meet criteria. Center staff should work											

with State Office to correct this issue.

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: 192	104	90	103	82	99	4	25	102
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.	11% 2/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	1/2	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	Individual has made progress on his/her goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	When there is a lack of progress, the discipline member or the IDT takes necessary action.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. and b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #192 – falls, and other: pica; Individual #104 – circulatory, and dental; Individual #90 – aspiration, and GI problems; Individual #103 – respiratory compromise, and skin integrity; Individual #82 – cardiac disease, and constipation/bowel obstruction; Individual #99 – diabetes, and GI problems; Individual #4 – weight, and constipation/bowel obstruction; Individual #25 – infections, and seizures; and Individual #102 – skin integrity, and UTIs).

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 #82 – cardiac disease, and Individual #25 – seizures.

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

Outcome 5 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.											
Summary: Given that over the last 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 Score	192	104	90	103	82	99	4	25	102
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% 0/10	0/2	N/A	0/2	0/1	N/A	0/1	0/1	0/1	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 generally was not provided to support that individuals' IHCPs were implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. The following provide a few examples of concerns noted:

- For Individual #90, intake and output documentation was not submitted.
- Individual #103 was at high risk for respiratory compromise, and direct support professional staff were to complete trigger sheets on each shift. The Center provided trigger sheets for September, October, and November 2017. For each month, blanks were noted on the trigger sheets, but day, evening, and night nursing staff had not initial the sheets showing they had reviewed them for any of the three months. Similar problems were noted for Individual #90.
- Individual #103 received oxygen, but no data sheets were submitted showing monitoring of the nasal cannula placement to address skin integrity issues, or nursing staff observations of the site to identify irritation or changes in skin with use of the oxygen prongs. On 12/3/17, Individual #103 was diagnosed with a Stage III nare decubitus.
- Individual #99 was supposed to drink two liters of fluids per day. Tracking of fluid intake was not provided in the records or summarized in the nursing assessments.
- For Individual #4, bowel records were provided for September through December 4, 2017, and there were no blanks for any of the shifts, which was good to see. However, IPN documentation was not present to allow the Monitoring Team to determine if nursing staff followed up on his daily bowel movements, and IView did not provide such data. For example, the bowel records indicated that on 9/21/17 and 9/22/17, he did not have a bowel movement, but no corresponding IPNs were found to show nursing follow-up.

- Individual #102 had a Foley Catheter, but no intake/output sheets were provided.

b. Evidence generally was not found to show that IDTs took immediate action in response to risk. The following provide a few examples of concerns noted:

- Individual #90 experienced recurrent emesis (i.e., emesis on 6/7/17 times four, 6/8/17 times three, 6/10/17 times four, and 6/14/17). However, his IDT did not meet to address this issue.
- On 9/8/17, Individual #90 was hospitalized for respiratory distress, and on 9/16/17, he was discharged with diagnoses of sputum, and possible Pseudomonas Aeruginosa. The IDT met and held a post-hospital ISPA meeting, and also discussed PNMT recommendations. The discussion revolved around weight loss, and did not include any recommendations to address his respiratory status. There were two recommendations for the PNMT to continue to follow weight and emesis trends, and collaborate with IDT. The IDT did not discuss recommendations related to nursing supports, such as modifying the IHCP to include regular, and measurable nursing assessments or interventions.
- On 11/13/17, Individual #103's IDT held an ISPA meeting to discuss her Level of Supervision (LOS) related to the need to have an oxygen nasal cannula in place due to oxygen desaturation. The text indicated that: "[Individual #103] has required to have the nasal cannula repositioned back in place at least 4x during the day up to 11x during the day." On 12/3/17, Individual #103 was diagnosed with a Stage III nare decubitus. However, based on ISPAs submitted, the IDT did not meet to further discuss this issue.
- Upon Individual #25's return from the hospital on 9/12/17 for arrhythmia/irregular heartbeat, the IDT did not hold a post-hospital ISPA meeting to discuss any needed changes to her IHCPs.
- On 11/20/17, Individual #102's IDT held a post-hospitalization ISPA meeting. The PCP was not present, nor was the Infection Preventionist. The IDT did not discuss or include recommendations for the prevention of UTIs and/or management of his Foley catheter. Although the ISPA documented IDT discussion of his acute care plan, it did not mention modifications to the IRRF or IHCP.

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: 1) nurses administering medications according to the nine rights; and 2) following individuals' PNMPs while administering medications. 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: 192	104	90	103	82	99	4	25	102
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R			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).	80% 4/5	N/A	N/A		1/1	0/1	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 aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	0% 0/2	N/A	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A
	ii. If an individual was diagnosed with acute respiratory compromise and/or a pneumonia/aspiration pneumonia since the last review, and/or shows current signs and symptoms (e.g., coughing) before, during, or after medication pass, and receives medications through an enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	N/R									
f.	Individual's PNMP plan is followed during medication administration.	100% 5/5	N/A	N/A		1/1	1/1	1/1	1/1	1/1	
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	80% 4/5	N/A	N/A		0/1	1/1	1/1	1/1	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	N/R									

	followed, and any untoward change in status is immediately reported to the practitioner/physician.											
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 #192 (who refused medications on three different occasions), Individual #104 (who refused medications on two different occasions), Individual #103, Individual #82, Individual #99, Individual #4, and Individual #25.

c. It was positive that for most of the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration. The exception was for Individual #82 for whom his ear was not positioned correctly for ear drops, which compromised the correct route of medication.

d. For both Individual #90 and Individual #103, although their IHCPs included action steps for nurses to conduct lung sounds before and after medication administration and enteral feedings, documentation in IView did not support that nurses completed the lung sounds as part of these activities.

f. During observations, it was positive that nurses used the individuals' PNMPs, and checked the position of the individuals prior to medication administration.

g. For the individuals observed, nursing staff generally followed infection control practices, which was good to see. The exception was the nurse that did not follow procedures for cleaning the stethoscope after she removed it from around her neck (i.e., she only cleaned the bell).

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: Some regression was noted with regard to individuals being referred to the PNMT, when needed. In addition, overall, IDTs and/or the PNMT did not have a way to measure clinically relevant, achievable, and measurable outcomes related to individuals' physical and nutritional management at-risk conditions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102

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;	11% 1/9	N/A	0/2	0/1	0/1	1/2	0/2	N/A	0/1	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	11% 1/9		0/2	0/1	0/1	1/2	0/2		0/1	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/9		0/2	0/1	0/1	0/2	0/2		0/1	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/9		0/2	0/1	0/1	0/2	0/2		0/1	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/9		0/2	0/1	0/1	0/2	0/2		0/1	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	70% 7/10	2/2	N/A	2/2	0/1	N/A	N/A	0/2	1/1	2/2
	ii. Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/10	0/2		0/2	0/1			0/2	0/1	0/1
	iii. Individual has a measurable goal/objective, including timeframes for completion;	10% 1/10	0/2		0/2	0/1			1/2	0/1	0/1
	iv. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/2		0/2	0/1			0/2	0/1	0/1
	v. Individual has made progress on his/her goal/objective; and	0% 0/10	0/2		0/2	0/1			0/2	0/1	0/1
	vi. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/2		0/2	0/1			0/2	0/1	0/1

Comments: The Monitoring Team reviewed nine goals/objectives related to PNM issues that six individuals' IDTs were responsible for developing. These included goals/objectives related to: choking, and weight for Individual #104; skin integrity for Individual #90; GI problems for Individual #103; falls, and choking for Individual #82; choking, and weight for Individual #99; falls for Individual #25; and skin integrity for Individual #102.

a.i. and a.ii. The goal that was clinically relevant, achievable, and measurable was Individual #82's goal to address falls that read: "By

6/18/17, he will walk ~500 feet in the mod GT [modified gait trainer] with min a [minimal assistance] w/~50 feet step-through pattern."

b.i. The Monitoring Team reviewed 10 areas of need for six individuals that met criteria for PNMT involvement, as well as the individuals' ISPs/ISPAs to determine whether or not clinically relevant and achievable, as well as measurable goals/objectives were included. These areas of need included: falls, and GI problems for Individual #192, aspiration, and weight for Individual #90, weight for Individual #103, aspiration, and weight for Individual #4, weight for Individual #25, and other: return to oral eating for Individual #102.

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

- Based on the documentation provided, it was unclear when Individual #103's IDT referred her to the PNMT. On 5/1/17, she met criteria for referral due to a weight loss of 7.65% between 4/4/17 and 5/1/17. The PNMT did not review her until 5/15/17. Between 4/4/17 and 6/28/17, she experienced a total of a 12.68% weight loss (i.e., 83.6 to 73 pounds).
- On 6/21/17, the PNMT reviewed Individual #4 for weight loss, and the explanation provided was that he met criteria when he lost 5.025% of his body weight in 30 days (i.e., 83.60 pounds on 5/1/17 to 79.80 pounds on 6/21/17, which is actually a 4.5% loss of body weight). However, on 5/15/17, Individual #4 weighed 78.2 pounds, which represented a 6.46% loss since 5/1/17. The IDT should have referred him to the PNMT over a month earlier than they did.

  In addition, from 7/20/17 to 7/24/17, Individual #4 was hospitalized. The discharge diagnosis was urosepsis, but according to a chest x-ray at the hospital, aspiration pneumonia could not be ruled out. Although the PNMT conducted a post-hospitalization review, they did not make a self-referral. From 8/13/17 to 8/15/17, Individual #4 was subsequently hospitalized for aspiration pneumonia, and it was not until after that hospitalization that the PNMT conducted a review.

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 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: weight for Individual #4.

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

Outcome 4 – Individuals' ISP plans to address their PNM at-risk conditions are implemented timely and completely.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	The individual's ISP provides evidence that the action plan steps were	6%	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	1/2

	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.	1/18									
b.	When the risk to the individual increased or there was a change in status, there is evidence the team took immediate action.	8% 1/12	0/2	0/2	1/2	0/1	N/A	0/1	0/2	0/1	0/1
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	0% 0/3	N/A	N/A	N/A	N/A	N/A	N/A	0/2	N/A	0/1

Comments: a. As noted above, most of IHCPs reviewed did not include all of the necessary PNM action steps to meet individuals' needs. However, the IHCP for which documentation was found to confirm the implementation of the PNM action steps that were included was for skin integrity for Individual #102.

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

- In November 2017, Individual #104 swallowed a foreign object. During a hospitalization from 11/8/17 to 11/13/17, a 10 to 15 cm hyper-dense tubular structure was found in his duodenum. On 11/14/17, the IDT held an ISPA meeting. Although the IDT stated that the current plan was not effective, they did not develop alternative strategies that might be effective at reducing his high risk for choking.
- On 6/6/17, Individual #90's IDT held an ISPA meeting to address weight loss. Although, at that time, the IDT thought the changes in weight might be due to inaccuracies in weighing him (e.g., weights taken with formula and water bags, at different times, with his shoes on), it did not appear that the IDT ever established an etiology. The IDT met again on 6/13/17, and again on 6/21/17, the IDT held a post-hospitalization ISPA meeting related to bowel obstruction and dehydration. On 6/26/17, the IDT made a PNMT referral, but Individual #90 returned to the hospital on that date. On 6/28/17, he returned to the Center, and the IDT held an ISPA meeting to discuss a referral for palliative care. The PNMT initiated a comprehensive assessment for completion on 7/26/17. When the IDT met to further discuss palliative care, they decided he had improved: his weight stabilized, he had no emesis, and was tolerating feeding. They increased his feeding and documented that they would consider hospice if he was hospitalized again. On 8/1/17, the IDT met with the PNMT to review its assessment. However, it did not appear that the IDT reviewed and rewrote the IHCP to reflect a new plan in a clear, concise, and focused manner. The group did not address all the PNMT's recommendations.
- Between 4/4/17 and 6/28/17, Individual #103 experienced a total weight loss of a 12.68% (i.e., 83.6 to 73 pounds). On 5/1/17, she met criteria for referral to the PNMT due to a weight loss of 7.65% between 4/4/17 and 5/1/17. The PNMT did not review her until 5/15/17, and an ISPA meeting was held on the same date. The action the team discussed was to monitor her weight, but the group outlined no parameters that would trigger specific actions. On 6/13/17, the IDT met again, and agreed to increase the tube feeding rate, given that she had tolerated a previous increase, but continued to lose weight. The IDT and PNMT did not document discussion of other issues that might impact weight loss. The only recommendation made during this meeting was that the PNMT would continue to monitor her.
- On 11/20/17, Individual #102's IDT held an ISPA meeting with the PNMT to discuss a skin integrity goal, but no outcome for this meeting was documented. On 11/28/17, staff reported a skin tear/pressure lesion on his right coccyx/buttock. The PNMT note, dated 11/29/17, outlined a clear plan. On 12/4/17, the IDT held an ISPA meeting to discuss his post-hospitalization

status, the need for a Change of Status IHCP, and PNMP changes. Individual #102 had a blister on his right heel at that time. Although the IDT discussed changes to his PNMP, they did not revise his IHCP to include all the recommendations the PNMT made, or provide justification for not including them.

c. For Individual #4, the PNMT and IDT did not discuss and/or develop integrated plans to address his aspiration or weight loss issues. Similarly, Individual #102's IDT did not appear to work with the PNMT to develop an IHCP to address his tube placement, hydration risk, oral medication administration compliance, oral nutritional intake, and/or potential for tube removal and plan to address this.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: During numerous observations, staff failed to implement individuals' PNMPs as written. PNMPs are an essential component of keeping individuals safe and reducing their physical and nutritional management risk. Implementation of PNMPs is non-negotiable. The Center should determine the issues preventing staff from implementing PNMPs correctly (e.g., competence, accountability, etc.), and address them. These indicators will remain in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	57% 26/46	
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.	30% 3/10	
Comments: a. The Monitoring Team conducted 46 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during five out of 11 observations (45%). Staff followed individuals' dining plans during 16 out of 28 mealtime observations (57%). Staff completed transfers correctly during five out of six observations (83%). Staff followed PNMP instructions for oral care in zero out of one observation (0%).			

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	192	104	90	103	82	99	4	25	102
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along	0% 0/2			0/1	N/A					0/1

	the continuum to oral intake are implemented.										
Comments: a. Neither Individual #90 (e.g., lollipop program) or Individual #102's (e.g., acceptance of oral intake) IDTs had developed a measurable plan to assess their progress along the continuum to oral intake.											

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: Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to formal OT/PT services and supports. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	22% 2/9	0/1	0/1	1/3	N/A	1/1	0/1	0/1	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	11% 1/9	0/1	0/1	1/3		0/1	0/1	0/1		0/1
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/8	0/1	0/1	0/2		0/1	0/1	0/1		0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/8	0/1	0/1	0/2		0/1	0/1	0/1		0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/8	0/1	0/1	0/2		0/1	0/1	0/1		0/1

Comments: a. and b. Based on information reviewed, Individual #103 did not require a goal/objective, but did need PNM supports as outlined in her PNMP related to her activities of daily living, and health needs. Individual #25 did not need a goal/objective because she is functionally independent in mobility with supports (i.e., she self-propelled her wheelchair, graduated to a lighter weight gait pacer, and required stand by or minimal assistance; and she was visually impaired so it was likely that she would continue to need stand by guidance to maneuver in her environment in the gait pacer).

The goal/objective that was clinically relevant and achievable, as well as measurable was for Individual #90 (i.e., performing stand pivot transfers). Although Individual #82's goal/objective for direct therapy (i.e., "By 6/18/17, he will walk ~500 feet in the mod GT [modified gait trainer] with min a [minimal assistance] w/~50 feet step-through pattern.") was clinically relevant, it did not include performance criteria (i.e., how many trials over what period of time).

c. through e. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, integrated progress reports with data and analysis of the data generally were not available to IDTs. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/3	N/A	N/A	0/2	N/A	0/1	N/A	N/A	N/A	N/A
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	33% 1/3	N/A	N/A	0/2	N/A	1/1	N/A	N/A	N/A	N/A
Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. b. For Individual #90, because of the lack of summary information in QIDP integrated ISP reviews for these goals/objectives, it was unclear whether or not they had been discontinued.											

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 – 100%, Round 10 – 70%, Round 11 - 79%, Round 12 – 80%, and Round 13 – 64%), 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.			Individuals:								
#	Indicator	Overall Score	4	25	28	102	127	93	129	118	15
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.	64% 7/11	0/1	1/1	1/1	1/1	1/1	0/1	0/1	1/1	1/1
		Individuals:									
#	Indicator		103	107							

c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	0/1							

Comments: The Monitoring Team conducted observations of 11 pieces of adaptive equipment.

c. Based on observation of Individual #4, Individual #93, Individual #129, and Individual #107 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, three indicators were moved to, or were already in, the category of requiring less oversight. For this review, two other indicators, in communication, 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.

It was good to see that staff were generally able to describe individual's health and behavioral risks.

A lot of work went into the development of the ISPs, however, implementation and data collection were poor.

For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals.

It was good to see that most individuals' AAC devices were present and readily accessible. As a result of sustained performance in this area, the related indicator will move to the category of less oversight. Unfortunately, when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.

SAPs did not have reliable data. For those SAPs for which the facility reported no progress, no actions were taken to modify the SAP. SAPs did not contain the necessary components. For most, there was no skill acquisition training sheet.

The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the onsite week. The Monitoring Team found most of them to be consistently engaged. Overall, the Monitoring Team was impressed with the improvements in individual engagement across the campus.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: A lot of work went into the development of the ISPs, however, implementation and data collection were poor. Implementation and data are required if this set of indicators is to be determined. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	63	192	104	159	103	90			

		Score									
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. Overall, personal goals did not meet criterion as described above, therefore, there was no basis for assessing progress in these areas. For 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 (i.e., indicator 3).

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

QIDPs acknowledged that lack of implementation data was a problem and were developing a plan to address this facility wide.

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

Summary: It was good to see that staff were generally able to describe individual's health and behavioral risks. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	63	192	104	159	103	90			
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/5	0/1	0/1	0/1	0/1	0/1	N/A			
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. Overall, direct support staff were generally able to describe individual's health and behavioral risks. This was good to see.

Staff, however, were not fully implementing ISPs, so it was difficult to verify that they could exhibit competence in implementing support plans. ISPs rarely included detailed instructions to guide staff when implementing the ISP.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report. IDTs need to monitor the implementation of all action plans and address barriers to implementation.

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	179	63	9	192	104	26	30	159	153
6	The individual is progressing on his/her SAPS	0% 0/23	None	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	0% 0/1	None	0/1	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% 0/9	None	0/2	0/1	0/1	0/3	N/A	0/2	N/A	N/A
9	Decisions to continue, discontinue, or modify SAPs were data based.	29% 4/14	None	0/3	0/1	1/2	0/3	N/A	1/3	2/2	N/A

Comments:

6. No individual had reliable data indicating he or she was making progress. Some of the SAP data indicated no progress (e.g., Individual #63's kick the ball SAP). Some SAPs appeared to be progressing (e.g., Individual #192's greet staff SAP), however, the data were not demonstrated to be reliable (see indicator #5), so these SAPs were not scored as progressing. Other SAPs had insufficient data to determine progress (e.g., Individual #9's match numbers SAP) and were scored as 0 because the data were not demonstrated to be reliable.

7. Individual #63's SAP to learn to say hi was achieved in November 2017, however, it continued.

8. None of the nine SAPs judged as not progressing (e.g., Individual #30's put on her shirt 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 29% of SAPs (e.g., Individual #159 was progressing in his crossing the street SAP and training was continuing). Ensuring that the continuation, discontinuation, or modification of SAPs is data-based should be a priority for El Paso SSLC.

Outcome 4- All individuals have SAPs that contain the required components.											
Summary: SAPs did not contain the necessary components. For most, there was no skill acquisition training sheet. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153

13	The individual's SAPs are complete.	4% 1/23	None	0/3	0/3	0/3	1/3	0/3	0/3	0/2	0/3

Comments:
13. In order to be scored as complete, a SAP must contain 10 components necessary for optimal learning. Individual #104's use the communication mat SAP was judged to be complete. This was the only SAP that contained a skill acquisition training sheet. The other SAPs reviewed only included the objective and, in some cases, how to respond to correct and incorrect responses.

El Paso SSLC needs to ensure that each individual has SAPs that include complete training instructions and contain the 10 components necessary for optimal learning referenced above.

Outcome 5- SAPs are implemented with integrity.											
Summary: Without proper SAP development, implementation is not likely to be (and wasn't) done correctly. Improvements to SAPs and a regularly plan for integrity checks are needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153
14	SAPs are implemented as written.	0% 0/1	None	N/A	N/A	N/A	0/1	N/A	N/A	N/A	N/A
15	A schedule of SAP integrity collection (i.e., how often it is measured) and a goal level (i.e., how high it should be) are established and achieved.	0% 0/23	None	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3

Comments:
14. The Monitoring Team observed the implementation of several SAPs. For most, however (e.g., Individual #30's use of a switch SAP), it could not be determined if they were implemented as written because specific implementation details were not available.

The one SAP that included training instructions (i.e., Individual #104's use of the communication mat) was implemented as written, however, the staff scored it incorrectly and it was scored a 0.

15. El Paso SSLC did not have a specific schedule of SAP integrity collection and a goal level. It is recommended that the facility establish that each SAP would be monitored at least every six months and that IOA and integrity would be at least 80%. At the time of the review none of the SAPs had integrity assessments.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: Development of a SAP system at El Paso SSLC is needed and this is reflected in the scores for these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	153

16	There is evidence that SAPs are reviewed monthly.	0% 0/23	None	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3
17	SAP outcomes are graphed.	0% 0/23	None	0/3	0/3	0/3	0/3	0/3	0/3	0/2	0/3

Comments:
16. Some SAPs were not reviewed in QIDP monthly reports (e.g., Individual #153's call the campus coordinator SAP), others did not include SAP data (e.g., Individual #9's match numbers 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 #30's operate a switch SAP).

17. None of the SAPs had graphed data.

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

Summary: Indicators 18 and 21 improved to the highest scores of any El Paso SSLC review. The Monitoring Team observed many individuals (including those not in the review group) engaged in activities. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 179	63	9	192	104	26	30	159	153
18	The individual is meaningfully engaged in residential and treatment sites.	78% 7/9	1/1	0/1	1/1	1/1	0/1	1/1	1/1	1/1	1/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	33% 3/9	0/1	1/1	1/1	1/1	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 seven (Individual #153, Individual #159, Individual #30, Individual #26, Individual #192, Individual #9, and Individual #179) of the nine individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). Overall the Monitoring Team was impressed with the improvements in individual engagement across the campus.

21. El Paso SSLC conducted monthly engagement measures in all residential and day programming sites. Their established goal was individualized across treatment sites. The facility's engagement data indicated that 33% of the residential and day treatment sites of the individuals reviewed achieved their engagement goals.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	179	63	9	192	104	26	30	159	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: 22-24. There was evidence that all of individuals participated in a wide range of 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 is in the less oversight category, however, attention to integrating the school program into the ISP was not evident and needs to be in order for this indicator to stay in this category after the next 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: 25. Individual #159 was under age 22 and attending public school at the time of the onsite review. He received educational services, and his IDT did participate in IEP meetings and exchanged educational information with the school. Individual #159's educational services were not, however, integrated into his ISP (e.g., ISP action plans to support his ISP, such as improve math skills, address school attendance, etc.).											

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: For individuals reviewed, IDTs did not have a way to measure clinically relevant outcomes related to dental refusals. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/4	0/1	0/1	0/1	N/A	N/A	0/1	N/A	N/A	N/A
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/4	0/1	0/1	0/1			0/1			
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/4	0/1	0/1	0/1			0/1			
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/4	0/1	0/1	0/1			0/1			
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/4	0/1	0/1	0/1			0/1			
Comments: a. through e. For the four individuals that had refused dental services, IDTs had not developed specific goals/objectives related to their refusals.											

Communication

Outcome 1 – Individuals with formal communication services and supports make progress towards their goals/objectives or teams have taken reasonable action to effectuate progress.											
Summary: Overall, IDTs did not have a way to measure clinically relevant, achievable, and measurable outcomes related to formal communication services and supports. These indicators will remain under active oversight.			Individuals:								
#	Indicator	Overall Score	192	104	90	103	82	99	4	25	102
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/7	N/A	0/2	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	0% 0/7		0/2	0/1	0/1	0/1		0/1	0/1	

c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/7		0/2	0/1	0/1	0/1		0/1	0/1	
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/7		0/2	0/1	0/1	0/1		0/1	0/1	
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/7		0/2	0/1	0/1	0/1		0/1	0/1	

Comments: a. and b. Individual #192 and Individual #99 had functional communication skills, and based on assessment information, Individual #102 did not require a communication goal/objective.

None of the remaining individuals' ISPs included communication goals/objectives that were clinically relevant, as well as measurable.

c. through e. As noted above, Individual #192 and Individual #99 had functional communication skills, and Individual #102 did not require a communication goal. Individual #99 was part of the outcome group, so further review was not conducted for him related to communication. Individual #192 and Individual #102 were part of the core group, so full reviews were conducted for them. For the remaining six 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	192	104	90	103	82	99	4	25	102
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	0/2	0/1	0/1	0/1	N/R	0/1	N/A	N/A
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	100% 1/1							1/1		

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. Examples of concerns included:

- For some individuals, monthly reviews were missing entirely or for some months in the review period (e.g., Individual #103, Individual #90);
- Sometimes, monthly reviews did not address the goal/objective (e.g., Individual #82).
- At times, the QIDP indicated no data was available, but it was unclear what, if any, action was taken (e.g., Individual #104, Individual #4).

b. On 10/2/17, Individual #4's IDT met to discuss and approve discontinuation of the direct therapy for the music box, and to replace it with a service objective. Although the IDT followed the procedure for terminating the service, it was not clear that the IDT had the data

necessary to make a good decision. The goal/objective as written was not measurable, and the monthly review indicated there was no data for the month of August, and no monthly summary for September.

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: It was good to see that most individuals with AAC/EC devices whom the Monitoring Team observed had their devices readily available. This has been a consistent finding for this review and the previous two (Round 11 – 83%, Round 12 - 87%, and Round 13 – 83%). As a result, Indicator a will move to the category of less oversight. However, the Center should focus on ensuring that staff prompt individuals to use them in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	104	63	25	82	19	40			
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	Not rated.									
Comments: a. and b. Although in most instances individuals observed had their AAC/EC devices present, it was concerning that often when opportunities for using the devices presented themselves, staff did not prompt individuals to use them.											

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

This Domain contains five outcomes and 20 underlying indicators. Five indicators were moved to, or were already in, the category of requiring less oversight after the last review and all remain in that category. For this review, an additional indicator was moved to this category and one was removed from 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.

Since the last review, the long-term admissions placement coordinator (APC) had retired and one of the admissions placement department staff was promoted to this APC position. In addition, one of the QIDPs transferred to the transition specialist position. Even with these staffing changes, the Center continued to make progress and the staff remained very motivated and committed to successful transitions. Moreover, they were in agreement with the Monitoring Team's comments during the onsite review meeting. They were cognizant of their needs and had active efforts underway to address them.

There were two transitions since the last review. This compared with six at the time of the last review. There were five individuals on the referral list. This compared with six at the time of the last review, too.

El Paso SSLC improved the wording (measurability) of the supports and the comprehensiveness of the list of supports. To increase the likelihood that no important needs were overlooked, a template-for-supports was used that covered all the various categories of supports. This strategy held promise, but still needed to be refined in its application because it sometimes led to inconsistencies, lack of clarity, and even an occasional failure to include some supports.

The Center was implementing positive practices for pre-move collaboration and interaction between provider and Center staff, such as provider staff shadowing Center staff at El Paso SSLC and Center staff participating in pre-move provider visits.

Pre-move training continued to need improvement, but it was good to see the Center had begun to consider various training modalities based on the need. The Center should focus on defining clear and measurable supports with specific competency criteria and develop competency testing needed to reflect that. It was very good to hear from transition staff that the Center was working on these needs and also planned to place increased emphasis on provider staff demonstration and not just written tests.

Transition assessments continues to need work, particularly in terms of providing recommendations to support transition and that addressed community living needs, and some assessments had not been updated as needed.

Post move monitoring remained very strong, in terms of attention to detail, documentation, and identifying need for and taking follow-up actions. Often, the Post Move Monitor looked for evidence of supports that was more comprehensive than what was included in the CLDP.

One individual exhibited challenges behavioral issues. The Center made good use of the PDCT process to thoughtfully self-review the individual's transition and use that information to plan for improvements in the future for other transitions for other individuals.

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 had improved the wording of the supports and the comprehensiveness of the list of supports. El Paso SSLC worked to ensure that no important needs were overlooked. To do so, a template-for-supports was used that covered all the various categories or supports. This strategy held promise, but still needed to be refined in its application because it sometimes led to inconsistencies, lack of clarity, and even an occasional failure to include some supports. Both indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	200	114							
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: Two individuals (Individual #200, Individual #114) transitioned from the Center to the community since the last review. Both individuals transitioned to group homes that were part of the State's Home and Community-based Services (HCS) program. The Monitoring Team reviewed these two transitions and discussed them in detail with the El Paso SSLC SLC Admissions and Placement staff while onsite.

Outcome 1 considers whether the Center's IDTs developed a clear and comprehensive set of supports needed to serve an individual in a community setting. The Monitoring Team appreciated El Paso SSLC's efforts to ensure that no important needs were overlooked. These efforts included using a sort of template-for-supports that considered the recommendations across a set of disciplines and categories,

including quality of life, medical, nursing, dental, pharmacy, dietary, habilitation, speech-language, psychiatry, behavior, education, vocational, recreational, residential, and administrative. This appeared to be a strategy that held promise, but the Center still needed to refine its application because it sometimes led to inconsistencies, lack of clarity, and even an occasional failure to include some supports. These are described in more detail below.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. Overall, the Center made progress, but did not yet meet criterion for this indicator. To move toward compliance, the IDTs should continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) could accurately judge implementation of each support. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The respective IDTs developed 32 pre-move supports for Individual #200 and 23 pre-move supports for Individual #114. Most of these supports described pre-move training for provider staff. The Center must describe how it will verify that provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used, and the competency criteria.
    - It was positive the Center included details about content of the training. To continue to move toward compliance, the IDTs should carefully consider how it organizes training needs so they are both cohesive and clear. The CLDPs used a template that organized supports into certain key areas, such as medical, nursing and habilitation. At times, this resulted in a training support being referenced across two or more areas.

      For purposes of presenting provider staff with clear, consistent, and cohesive training, the IDT should consider consolidating and synthesizing supports where possible. The habilitation/physical therapy support for Individual #114 provided a good example of a clear and cohesive support that described his needs for levels of assistance needed for transfers, bathing, toileting, dressing and grooming.

      This was not consistent, however. For example:
        - For Individual #200 supports in the residential and habilitation areas provided confusing instructions for provider staff. For example, the habilitation support called for minimal assistance for clothing orientation, to provide him with extra time, and encourage him to independently perform tasks. A residential post-move support indicated he needed maximum to total assistance with dressing. While the support also stated that he must always be allowed and encouraged to assist, these two supports provided a conflicting understanding for direct support staff about his level of independence.
        - Individual #114 did not have a clear and comprehensive support for training provider staff on his dining techniques. He had three supports (dietary, habilitation-speech, and speech/language) that referenced diet texture and adaptive dining equipment. None provided a complete and cohesive set of related requirements. In addition, the occupational/physical therapy (OT/PT) assessment included additional recommendations

regarding dining that were not found in any of the aforementioned training supports. These included important techniques that staff provider should know, such as (1) when displaying repetitive twisting/turning head movement during meals, place the spoon in front of his mouth, wait for him to stop moving his head, and he will open his mouth and/or move toward the spoon when he is ready to eat, (2) provide steadying assistance on Wonder-Flo cup, be ready in the event he decides to throw cup, (3) monitor his pace of liquid intake as he may drink too quickly, and 4) if he refuses to eat, give him two to three minute breaks, then try to assist him again. If he continues to refuse, offer him up to three alternative meal choices. However, if he is eating well, offer a second serving of food.

- The pre-move training supports that were included did not clearly indicate if the prescribed content also represented the specific competency criteria needed to confirm essential staff knowledge. Some pre-move training supports included narrative informational summaries in addition to specific supports, but it was not clear whether this indicated the information was to be included in staff training and/or represented essential staff knowledge/competencies. For example, the pre-move dental training support for Individual #114 provided specific steps to be followed during oral care. This was positive and would be important knowledge for staff providing his daily care. It also described when he last was seen under general anesthesia, and that this included a comprehensive exam, full mouth x-rays, periodontal charting and four quadrants of scaling. It was not clear if it was the intent of the IDT to prioritize this item as essential staff knowledge in the same way as the steps for daily oral care.

- Post-Move: The respective IDTs developed 34 post-move supports for Individual #200 and 23 post-move supports for Individual #114. The post-move implementation supports were essentially the same in content and construction as the pre-move supports, so the same measurability issues applied. While the Monitoring Team appreciated the Center's efforts to provide ample detail about supports, the measurability (and comprehensibility) was often compromised by a lack of clarity that resulted from the IDT's failure to carefully edit and synthesize assessment narratives and recommendations. Additional examples are the following:
  - Individual #200's CLDP included post-move supports in the areas of medical and nursing related to monitoring for hyperprolactinemia, but neither specified what form the monitoring should take or when or how often it should occur.
  - Individual #200's CLDP also included a medical post-move support that indicated he should be followed by OT and PT due to ataxia, but this did not describe what form of follow-up was needed, or when. A post-move habilitation support indicated that the provider would need to ensure Individual #200 had access to community OT, PT, and speech/language pathology (SLP) for all habilitation supports, if needed. This did not provide any further measurable specificity.
  - Individual #114 also had a support that indicated he should have access to community OT, PT, and SLP for all habilitation supports, if needed. It did not indicate how the provider could or should evaluate the need. In addition, recommendations from assessments were not clearly consistent with this support. The medical assessment indicated that he needed to be followed by OT and PT, but the OT/PT assessment indicated that their services were not needed.

2. The Monitoring Team considers seven aspects of the post-move supports in scoring this indicator, all of which need to be in place in order for this indicator to be scored as meeting criterion. The Center had identified many supports for these two individuals and it was

positive they had made a diligent effort to address their needs. Still, neither of these CLDPs fully and comprehensively addressed support needs and did not meet criterion, as described below.

- Past history, and recent and current behavioral and psychiatric problems: To meet criteria, the IDTs should continue to make improvement toward developing comprehensive supports to address behavioral and psychiatric needs. As described above, the current organizational template/methodology did not lend itself to development of cohesive supports in this area. Findings included:
    - The IDTs did not describe whether either individual would require behavioral consultation as a support after transition.
    - Both CLDPs included a support for the provider to ensure to follow the behavior support plan (BSP) and provided a list of target behaviors, but Individual #200's did not include the behaviors for increase or define expectations for staff knowledge in this area.
    - The CLDPs did not include supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. The CLDP for Individual #200 did not provide comprehensive supports that clearly identified all behavioral and psychiatric needs. For example, the medical assessment update indicated Individual #200 had been seen for self-inflicted bites on 6/30/17, 7/12/17, and 8/3/17, but none of the supports identified self-injury as a behavior provider staff needed to know. Similarly, the pharmacy section of the CLDP supports included a narrative statement that Individual #200 had psychiatric indicators of depression and suicidality, and further that he had not made any more attempts or statements of suicidality since a 5/24/17 incident. It did not specify any requirement for staff knowledge or staff action in the event such attempts or statements were made. Neither the behavioral health or psychiatric pre-move supports addressed suicidal attempts or statements, nor did any other support. Upon interview with the transition staff, Individual #200 laid down in the street during the 5/24/17 incident, which would have been a behavior for which community provider staff should be aware.
    - In the social work section of the CLDP narrative, Individual #200's IDT discussed that assessment's recommendation to redirect him when was being physically and verbally abusive and provide him with a change of environment. The PMM brought up the fact that a change of environment at the Center was usually comprised of a walk around the campus and that it would be necessary to identify what that support should look like in the community. Per the QIDP and behavioral staff, it was agreed that a change of environment in the community home could be his bedroom or the backyard; staff could then inform him that when he was calm, they could go for a walk outside with the walker. This was an excellent discussion for the IDT to have, and it was positive the PMM had the foresight to prompt it. Unfortunately, the IDT did not include this in the behavioral services support or in any other support.
    - The Monitoring Team was concerned about the wording of one of Individual #200's support for Habilitation in the area of OT, which appeared to characterize the use of his tilt wheelchair in part as a behavioral restraint. It indicated the wheelchair was used to support outside mobility due to uncoordinated movements and high risk of falls, but also as a support for behavioral outbursts and for safety during aggression and agitation. Transition staff, however, indicated during interview that this wording was inaccurate.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs developed some good supports related to safety, medical, healthcare, therapeutic and risk needs, such as for scheduling of health care appointments, but this

was not consistent. To meet criteria, the IDTs still needed to develop comprehensive and cohesive supports. For example:

- Neither CLDP clearly stated what level of nursing oversight the individual would require.
- For Individual #200, the CLDP narrative recommended a routine level of supervision. The CLDP included both pre-move and post-move supports for supervision that indicated he required 24-hour awake staff to attend to his personal care and needs. The post-move support also indicated staff should be available at both the home and day program to provide supervision and assistance as well as encouragement to perform his activities of daily living as independently as possible. The supervision support did not address staff knowledge of his tendency to unbuckle his seatbelt and stand and walk without assistance, which was one of his known risks for falls, although this was referenced in his IHCP support. The Monitoring Team also noted the IHCP support also addressed the need for staff to be aware of his location at all times and included a requirement for a door alarm to prevent episodes of flight. While it was positive that the IDT addressed all these factors in various supports, the support for supervision did not convey the scope of his needs in that area and could have led to confusion and error.
- For Individual #114, the CLDP did not address concerns about his weight with clear supports. Per the nutrition assessment provided for review, dated on 5/11/17, recommendations indicated his current weight was 100.78 pounds and that the main goal was for continued weight maintenance; further, the assessor would not like for Individual #114's weight to get below 90 pounds. On the other hand, the CLDP narrative indicated the nutrition assessment was dated 6/1/17 and the related summary stated a weight loss notification had been received on 5/10/17 from the nurse case manager, with a current weight of 100.58 pounds. According to the assessment, this was compared to a weight of 105.2 pounds three months earlier. The reason for this weight loss was undetermined at that time, as Individual #114 was reported to be eating well, with oral intake at 95%. The assessment further indicated the dietitian spoke with the nurse case manager and QIDP and all agreed to implement weekly weights and, if Individual #114's weight were to fall to 95 pounds or lower, a weight trigger would be sent to the dietitian. Per the CLDP narrative, the final recommendations included both the weekly weights and notification to the dietitian in the event his weight fell to 95 pounds. The dietary section of the CLDP supports did not include either of these recommendations. A pharmacy CLDP support did require weekly weights, but did not indicate the need for a notification to be triggered to a dietitian if Individual #114's weight fell to 95 pounds. Instead indicated notification would be required a two-pound gain or loss in two weeks, 7.5% gain or loss in three months, or 10% gain or loss in six months.

- What was important to the individual: Neither of the CLDPs met criterion. The Monitoring Team reviewed various documents to identify what was important to the individual, including the ISP, Preferences and Strengths Inventory (PSI), and the CLDP section that lists the outcomes important to the individual. Findings included:
  - For Individual #200, the CLDP included IHCP goals in the section devoted to identifying important outcomes and personal goals. It did not include any personal preferences or address personal goals related to leisure, work, relationships, or independence. Individual #200's ISP indicated that his family was very important to him, documenting he would like to be more in touch with his family his mother and his sister. He stated he would like to go spend the night at his mother's house and he had not done it as often as he would like. The only related support was for various quality of life preferences that included the following statement: he loves family visits; encourage family at least once per month. The ISP also indicated the IDT had determined Individual #200 would benefit from a guardian. Per the narrative, his mother had said she would like to apply, but the necessary papers had not been submitted. It

further stated the QIDP would follow up with his mother for status on filing for guardianship and, if she was not interested, the IDT would pursue other guardianship alternatives. The CLDP did not address this need, which could become more significant in community living.
    - For Individual #114, the IDT identified primarily environmental factors as important to him and these were addressed in the community setting.

- Need/desire for employment, and/or other meaningful day activities: Neither CLDP met criterion, as described below:
    - For Individual #200, the IDT did not develop an assertive employment support based on his needs. Per his ISP, he had a personal goal to work at a retail store as a floor associate and action plans included filling out job applications in the community. It indicated he stated he would like to work at Walmart picking up trash. The discussion narrative of the CLDP indicated he had submitted an application with the Texas Workforce Commission (TWC) to receive vocational rehabilitation services and was currently on a waiting list to be assigned a counselor. The vocational summary also noted he valued the freedom to have his own money, and to spend it as he wished, and recommended explaining to him that working provides income to make desired purchases. The IDT documented a discussion in which the PMM emphasized that the provider did not have opportunities for employment and that it was very important for the team to determine if work was an important element of Individual #200's life. She noted that in previous discussions it had been identified that work was not an important element of his life and that social stimulation was more important. The IDT determined that since Individual #200 often refused to work, regular employment would be difficult and, therefore, did not recommended for him to seek community employment. The IDT did not reconcile this determination with the ISP personal goals and vocational summary recommendation described above. It did not justify why the TWC referral would not be continued as it potentially offered Individual #200 significant employment supports, including job counseling, coaching, training, placement, retention, and follow-up.
    - For Individual #114, the IDT developed an educational support that described two training programs he should participate in. None of his supports included any meaningful day activities in integrated community settings. The IDT could have, for example, considered having him be involved in a community water recreation program, as per his ISP action plan.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. For both individuals, the IDTs defined supports regarding behavioral strategies that included some elements of positive reinforcement and other motivating components, but this was not yet consistent. For example, Individual #200's IDT did not develop a CLDP support to ensure he received a daily reinforcer at his community day habilitation program, a strategy that had been consistently implemented at the Center. This resulted in disruptive behavior at the community day program after transition until the PMM investigated the concern and recognized the absence of this needed support.

- Teaching, maintenance, participation, and acquisition of specific skills: The respective IDTs developed some supports related to teaching, maintenance, participation, and acquisition of specific skills, which was positive. Based on their needs, the CLDP for Individual #114 met criterion, but Individual #200's did not.
    - For Individual #200, the CLDP included a support that he should be offered a math class and money management lessons daily. It did not describe his current skill level or needs in these areas. Per his ISP, he had goals and action

plans to learn to take the Lift for transportation, to fill out job applications in the community, and a skill acquisition plan for safety awareness in his wheelchair. The OT/PT assessment indicated he had potential for greater independence using an electric razor. The CLDP did not address any of these, all of which would have been very appropriate to support his independence and safety in the community.
    - For Individual #114, the CLDP included an educational support to participate in programs to teach him to place his cup on the mat instead of throwing it and to place his dirty clothes in a hamper.

- All recommendations from assessments are included, or if not, there is a rationale provided: Overall, El Paso SSLC had a good process in place for documenting discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Center may wish to consider whether the CLDP could be made a more readable and utilitarian document by summarizing the assessments rather than by including each assessment in its entirety in the body. As described above, the Center was using a template-for-supports that included a range of topics in key areas. Prompts such as these can be valuable to ensure an IDT does not inadvertently fail to consider whether supports might be needed in each of the areas; still IDTs needed to be cautious about reliance on a template that may not have been fully comprehensive. For example, the supports template did not provide for full consideration of recommendations from the social assessment:
    - In its discussion of the social assessment for Individual #200, the IDT recommended a pre-move support for the PMM to communicate with his mother to re-inservice her about the importance of not promising to visit without being sure she would be able to follow-through. The CLDP indicated the mother's compliance with this would be a support needed to prevent any disappointment or anger due to false expectations of a visit, but it did not include this as a formal pre-move support. Similarly, the IDT agreed to develop a support for the provider to contact his mother the first week of every month to set up at least one visit a month with a date to add to Individual #200's calendar. The IDT also indicated the provider would be responsible for ensuring that at least one visit a month was arranged by provider. If mother wants to visit more frequently she will communicate with provider first. Individual #200 was to be made aware of the visit once she was on her way to avoid any disappointment. The CLDP did not include a related formal support. Per interview with the transition staff, Individual #200 had experienced good support in this area. This was positive, but it did not obviate the need for the CLDP to have included these as supports.
    - The IDT did not consistently integrate the final social work recommendations regarding Individual #114's preferences in the formal supports. For example, the narrative indicated a preference for listening to music and the team discussed that he owned his own radio. Based on this, a recommendation was made to provide him with opportunities for listening to music. The CLDP did not include a related support. Similarly, CLDP supports did not address the final recommendations for offering him a peanut butter and jelly sandwich in the event of meal refusals and offering ketchup during meals.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.	
Summary: Most, but not all supports were provided to individuals. Therefore, indicator 5 will remain in active monitoring. Improvements in the way the list of supports was written (indicators 1 and 2) are required for indicator 4 to remain in the category of less oversight. This also affected the PMM's ability to accurately	Individuals:

record the presence or absence of some supports. Therefore, indicator 6 will be returned to active monitoring. Follow-up continued to be done thoroughly, though for some supports, the problems regarding proper scoring (indicator 6) affected whether the support was properly designated for follow-up. There were no opportunities to observe the conduct of post move monitoring, so indicators 9 and 10 will also remain in active monitoring for review at the next onsite visit.											
#	Indicator	Overall Score	200	114							
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.	0% 0/2	0/1	0/1							
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.	Not rated	Not rated	Not rated							
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not rated	Not rated	Not rated							

Comments:

3. Post-move monitoring was completed at required intervals for both individuals. Each of these post-move monitoring visits were within the required timeframes, were done in the proper format and occurred at all locations where the individual lived or worked. The PMM included very detailed comments regarding the provision of every support. The Monitoring Team appreciated the significant effort made by the PMM in this regard, particularly given the lack of clarity and measurability in the construction of supports.

4. As indicated above, the PMM consistently made detailed comments regarding findings for every support. As a result of this positive practice, the Monitoring Team was frequently able to verify the availability of reliable and valid data upon which the PMM evaluated for the presence of supports, even when the supports themselves lacked clarity. It was also helpful that the PMM often identified more than one form of evidence (documentation, interview and observation) she used to confirm whether supports were in place as needed.

As noted above in indicators 1 and 2 and to maintain less oversight categorization for this indicator, the Center should improve overall clarity and measurability of supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. In some supports, the language was broad and vague, while others had inconsistent requirements as described above under Indicator #1. The PMM was to be commended for significant efforts to quantify her assessment regarding the presence of supports, but this required a great deal of subjectivity and frequently led to instances in which reliable and valid data were not obtained as further detailed below.

5. Based on information the Post Move Monitor collected, both individuals had frequently received supports as listed and/or described in the CLDP, but this was not yet consistent

As described above, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received supports due to the lack clarity and measurability in the supports as written. In other instances, the IDT did not include all needed supports as identified throughout the CLDP. Examples of supports not in place as required included the following:

- For Individual #200, the PMM documented errors in bowel movement monitoring at the time of the 45-Day PMM visit. It was positive she took immediate action to correct this concern.
- At the time of Individual #200's seven-day PMM visit, the provider had not completed a weekly weight.
- Individual #114's CLDP specifically stated he should be referred to the primary care physician (PCP) or dietitian if his weight fell to 95 pounds. The final support, however, was not revised to address this need, but should have been by the IDT. Per the 90-day PMM Checklist, the provider recorded his weight as 95 pounds on 9/11/17, but no referral was made.
- For Individual #114, a support indicated provider staff would monitor his bowel movements on a daily basis and report any issues to a provider clinician; specifically, it required the provider nurse to be notified if he did not have a bowel movement on the first day and that action must be taken by the end of the second day. The data indicated he had not had a bowel movement on five days, including one episode of two consecutive days without a bowel movement. The PMM did not reference any documentation that a clinician had been notified on any of these five days or that action was taken when he did not have a bowel movement for two consecutive days

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but this was not yet consistent. Accuracy was sometimes compromised by the lack of clarity and measurability in the construction of the supports.

- For Individual #200, the PMM marked the post-move dental support as not applicable at both the seven-day and 45-day PMM visits because the dental appointment was not yet due, however, the dental support also included extensive ongoing oral care recommendations that were not addressed in the PMM report.
- For Individual #114, at the time of the 90-day PMM visit, the PMM marked a support for monitoring bowel movements and reporting as in place, but the evidence did not reflect these requirements had been met.
- For Individual #114, as indicated above, the CLDP specifically stated he should be referred to the PCP or dietitian if his weight fell to 95 pounds, but the final support was not revised to address this need. Per the 90-day PMM Checklist, the provider recorded his weight as 95 pounds on 9/11/17, but no referral was made. The PMM noted he had lost a couple of pounds from the previous monitoring visit, but indicated there were no concerns. The support was marked as present. This conflicted with the needs described during the CLDP.
- Individual #114's post-move support #2 medical included requirements for nursing and direct care staff to monitor for side

effects per MOSES and DISCUS. The PMM comments did not address side effects for this support. Post-move support #5 for pharmacy also addressed side effects, but did not specify the need to perform MOSES and DISCUS monitoring. The PMM documented there that staff had knowledge of the side effects they needed to look out for and report but did not make any reference to the MOSES and DISCUS.

- Individual #114's post-move support #2A for medical indicated the PCP would be informed of the following: list of medications and indications; health status; lab and exam frequencies; dental needs and follow-up with the dentist; Darrell's integrated health care plans; follow-up appointments with specialists and contact information for the facility doctor and clinic for continuity of support and continuity of care. No PMM comments referenced how or if the PCP received this information. The 45-day PMM comments did indicate the PCP had checked vitals, reviewed and ordered labs and reviewed and refilled medications without making any changes. From that, a reader could infer that some of the information had been provided (i.e. medications and labs), but the comments did not reference the remaining listed items.
- Individual #200's post-move support #11 defined his target behaviors and listed three recommendations: (a) to continue his behavior contract which encouraged him to participate in daily activities for an opportunity to choose an outing during the week, (b) to provide him with plenty of opportunities to engage with peers and staff as many of his maladaptive behaviors are maintained by attention, and (c) that it would be beneficial to continue his PBSP and, additionally, that staff take prevention measures by having alternative options when precursor behaviors are apparent, such as when he unbuckles himself from the wheelchair, standing and walking without assistance, and disengaging from staff. At the time of the 7-day PMM visit, the comments did not reference whether the behavior contract as outlined above had been implemented or whether provider staff had knowledge of it. Instead, comments indicated an expectation that he would receive $14.00 at the end of the week. The comments also did not reference whether he had been provided with plenty of opportunities for engaging with peers and staff, or whether provider staff had knowledge of this prevention strategy. It was also not clear from the comments whether provider staff were implementing alternative options upon the observation of precursor behaviors or simply as a means of re-direction once target behaviors occurred. Overall, the evidence did not support the affirmative scoring.

7-8. These indicators focus on the implementation of corrective action in a timely manner when supports are not provided as needed and that every problem is followed up through to resolution. Whether follow-up is completed as needed relies heavily on the accuracy of the PMM's assessment of whether supports were, or were not, in place. That is, further, a function of accurately defining supports so that the PMM can accurately identify whether supports are in place. This, then, sets the occasion for follow-up actions to be taken.

Overall, the PMM was extremely diligent and effective in identifying issues that required follow-up and then acting to ensure timely action for resolution. For example:

- For Individual #200, the PMM identified unaddressed behavioral needs between the seven-day and 45-day PMM visits and took prompt action to notify the IDT, obtain needed information and convene the IDT to develop and implement a corrective action plan.
- Also for Individual #200, the PMM identified a delay in transitioning from institutional to community Medicaid coverage, which was delaying his ability to access health care providers. She obtained assistance from Disability Rights and the issue was quickly resolved.

9-10. There was no post move monitoring scheduled, therefore, Monitoring Team did not participate in post move monitoring during

the week of the onsite review. Thus, these two indicators were not scored.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.												
Summary: The Center engaged in a very product implementation of the PDCT process that identified missing supports from one individual's transition. Because these supports (and some others identified by the Monitoring Team), this indicator was scored 0 for that individual. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	200	114								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	50% 1/2	0/1	1/1								

Comments:

11. At the time the Center fulfilled the document request, neither individual had experienced a PDCT event. Upon interview during the onsite visit, transition staff reported Individual #200 had engaged in aggressive behavior the week before that resulted in provider staff injury and two episodes of law enforcement contact. PDCT documentation provided following the monitoring site visit indicated there were four separate events, spanning a period between 12/9/17-12/29/17. The IDT met on 1/25/18 to discuss and address these events. The IDT had also met earlier, on 10/23/17, to address behavioral concerns that arose between the seven-day and 45-day PMM visits. At that time, the IDT documented several strategies that had been implemented, including additional training for day habilitation staff and to be served by the Systemic Therapeutic Assessment Respite Treatment (START) program for behavioral supports in the community. Per the 45-day PMM Checklist, on 11/22/17, the PMM documented these issues and the efforts to resolve them. She also documented following up with the provider on two occasions, reporting on 11/28/17 that no behaviors had occurred since 11/23/17. No additional documentation was made until the 1/25/18 PDCT meeting, although, as noted above, transition staff has some knowledge of the events by 1/9/18 during the monitoring site visit.

The IDT documented the events were likely preventable and identified several more assertive supports the IDT could have put in place prior to the transition. These included additional overnight pre-placement visits, as had been recommended by the transition staff, but not accepted by the IDT. The IDT also identified the lack of a tested behavioral strategy to address his negative response to delayed gratification and the need for more robust provider staff training as supports that could have been implemented.

Overall, it was positive that the IDT completed this thoughtful critical analysis of the transition process that identified improvements that may have led to a better outcome. Other factors the IDT should have considered included:

- The PMM process and related follow-up procedures were not consistently timely enough to address emerging or continuing concerns with sufficient urgency. The IDT responded quickly to the initial notification of behavioral concerns in October 2017, with good follow-up action taken. The response to the events that occurred in December 2017 was not as timely, given that the

Center was aware of them by 1/9/18 and did not document any additional action until 1/25/18. At that time, the IDT did develop an assertive plan for providing onsite training and coaching for provider staff at the home and the day program. This was very positive, but not as timely as needed under the circumstances.

- The IDT did not have any discussion during the PDCT ISPA about the START program and its involvement, either during the PDCT events or on an ongoing basis in the future. This could be an important resource and it may have been prudent to coordinate the planned onsite training and coaching with START staff.

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: It was evident that El Paso SSLC transition staff were working on the requirements for this set of indicators, all of which are important for a successful transition. For instance, IDT members were involved in the various aspects of both transitions for this review and the two previous reviews, too. Therefore, indicator 13 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 200	114							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/2	0/1	0/1							
13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	100% 2/2	1/1	1/1							
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	100% 2/2	1/1	1/1							

17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	100% 2/2	1/1	1/1							
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. It was positive that transition staff had been working with several disciplines on the quality of transition assessments and recommendations, and some improvement was observed. This remained an area of need, however. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: Assessments provided for review consistently met criterion for timeliness, but the Center did not provide the following updated assessments:
  - The Center did not update the IRRF for either individual. It was positive the transition staff reported the IDTs had begun to update this document as a part of the transition process.
  - The Center did not provide updated vocational, communication, functional skills, or pharmacy/QDRR assessments for Individual #200.
  - The Center did not provide updated an updated psychiatric or pharmacy/QDRR assessments for Individual #114. The FSA and recreation assessments were provided, but had not been updated. The medical and residential assessments were not dated, so the Monitoring Team could not ascertain compliance.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status. Outdated and unavailable assessments impacted this finding, but updated assessments did not consistently meet criterion either. For example:
  - For Individual #200, neither the psychiatric or behavioral assessment referenced any suicidal statements or attempts in May 2017, as discussed in the pharmacy support section of the CLDP. Neither described the episodes of self-biting that occurred between June 2017 and August 2017, just prior to transition.
  - For Individual #114, the Monitoring Team could not confirm the medical assessment reflected current status as it was undated and its most recent specific references were dated in June 2016, just prior to his most recent ISP.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Assessments that had been updated did not yet thoroughly provide recommendations to support transition. For example, the medical assessment for Individual #200 did not provide specific recommendations for follow-up needed for hyperprolactinemia and cholelithiasis. For Individual #114, the recommendations from the residential discharge summary tended to be overly broad and vague. For example, recommendations included to continue receiving the care that he requires; to allow a daily schedule that is flexible; to be given to the opportunity continue to be independent as possible; and, to continue providing him with the things that he enjoys.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in

comprehensiveness and individualization. For example, the psychiatric assessment for Individual #200 did not provide any recommendation related to the use of ziprasidone, which had been discontinued shortly before his transition due to akathisia.

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

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: Training provided to community provider staff did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the materials, rosters and competency testing for all training provided related to these transitions. Findings included:

- The IDTs inconsistently identified the expected provider staff knowledge or competencies that would need to be demonstrated. Neither the supports or the training materials clearly defined criteria that would demonstrate provider staff were competent to provide for the individuals' health and safety.
- It was positive the Center described the type of training needed for provider staff and that this sometimes included in vivo and/or video demonstration as appropriate.
- It was positive the Center made an effort to define how provider staff competency would be confirmed, typically by a written exam requiring 100% as a passing grade. To continue to move toward compliance, the Center should ensure its written exams are constructed to cover all essential knowledge. The testing materials reviewed by the Monitoring Team fell short of this mark. Competency testing did not clearly document provider staff had knowledge of all essential supports based on each individual's needs. For example, testing did not specifically require provider staff to demonstrate specific knowledge of either individual's bowel monitoring needs, side effects monitoring, and/or weight monitoring requirements.
- In some cases, the Center affirmed provider competence by scoring a written test as achieving the 100% requirement, but a review of those tests did not support that conclusion. For example, Individual #200 had numerous adaptive equipment requirements, including a dycem mat, a deep dish, a plate guard, a brown unbreakable spoon, a spork, a Bentley 20 manual lift wheelchair, a 3:1 shower chair, a weighted gait trainer, and a plastic shower gait belt. The written test asked provider staff to list his adaptive equipment. One test included only the gait belt as an answer, but was scored as 100%. Another stated only "aggression in a tilt – wheelchair, HOBE," but was also scored at 100%.

15. When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual: The IDT should include in the CLDP a specific statement as whether any collaboration was needed, and if any completed, summarize findings and outcomes. Neither CLDP met criterion as described below. It was positive the Center had modified its CLDP to include a discussion of this transition need, but the IDTs needed to more fully consider strategies for facilitating needed collaboration, even in the face of barriers. For example:

- For Individual #200, the CLDP template included a series of questions for the IDT to discuss, including whether such collaboration was needed. This was a positive practice. The IDT did identify a need for a collaboration between the facility and community psychiatrist, agreeing that "(i)deally speaking" such a collaboration would be beneficial." The CLDP narrative went on to document that this contact could not be arranged at that time, however, due to funds, schedules and billing. Instead, the IDT determined only that the discharge summary and behavioral documentation would be provided to the community psychiatrist. If there were any questions, the provider would contact the Center to set up a conference for the psychiatrist to psychiatrist consult. It was positive the IDT identified the need for the collaboration, as Individual #200's psychotropic medication regime involved some issues related to prior reactions and decompensations, including one very recent discontinuation of a medication due to side effects. Once accurately identified as a need, the IDT should have made the necessary arrangements, either pre- or post-move. The psychiatry assessment did not make specific recommendations about these medication concerns, so it was not prudent to rely on that material to elicit possible questions.
- For Individual #114, the IDT documented a similar discussion. Per the narrative, the IDT discussed that while Individual #114 did not require a lot of active support, it would be beneficial for a discussion to take place between the Center and community psychiatrist to cover Individual #114's current psychiatric plans as well as the importance to not alter medications if possible. Regarding primary care, the IDT agreed it did not deemed the collaboration as necessary, though it would be beneficial. The narrative further indicated it was unfortunate this would not likely for the community at the time.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. Both CLDPs met criterion. The Center included a prompt for discussion of this transition need in its CLDP template, which was positive. The IDT indicated it did not need to complete any further settings assessments for Individual #200 because the team was familiar with home due to another recent transition from El Paso SSLC. For Individual #114, the IDT documented the IDT determined it was not necessary to visit the home given that transition team had provided them specifications of the home and all meet Individual #114's needs. In addition, IDT members accompanied Individual #114 at the time of his overnight visit and, based upon their observations reviewed by the team, it was again agreed no additional site assessment was needed.

17. The CLDP should include a specific statement of the IDT considerations of activities SSLC and community provider staff should engage in, based on the individual's needs and preferences, including any such activities that had occurred and their results. Examples include provider direct support staff spending time at the Facility, Facility direct support staff spending time with the individual in the community, and Facility and provider direct support staff meeting to discuss the individual's needs. The IDT included such a statement in the section entitled Community Living and described positive practices implemented for both transitions. Both CLDPs met criterion.

- The IDT documented El Paso SSLC staff accompanied Individual #200 during the first day of his extended overnight visit with the provider as a support to him as well as provider staff. Center DSP provided modeling of care (in vivo) as well as shared day to day preferences and supports.
- The CLDP for Individual #114 documented the provider team visited the Center and observed his room, transfers and environmental supports. In addition, Center staff accompanied him on his first overnight visit to the provider home.

18. LIDDA participation: Per interview, these two CLDPs met criterion. The IDT should be cautious, however, when using a template document to be sure it is both accurate and individualized. For example, for Individual #200, the CLDP indicated the LIDDA met with

legal guardian, provider and APC to discuss transition plan, but Individual #200 did not have a legal guardian. This oversight could cause the reader to question the actual involvement of the LIDDA.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. This was positive, but timeliness is only one component of compliance for this indicator. It is also essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility. The PMSRs for these two individuals did not accomplish this. Examples of concerns from this review included:

- Neither PMSR provided any evidentiary documentation to confirm pre-move supports were in place. Each requirement was checked off as in place, but did not describe how that was determined. For example, many pre-move supports required PMM visual verification as evidence to be obtained, and some required training rosters, but the PMSRs included no evidence (other than a checked box) to demonstrate the presence of the respective support. Just as with the PMM Checklists, the PMM should provide a succinct comment about the evidence relied upon to verify the support was in place.
- While the CLDP included numerous pre-move supports for pre-move training, these did not meet criterion for ensuring that provider staff were competent for either individual, as described above. The PMM did not document any provider staff interview that might have confirmed staff knowledge.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Referrals typically receive a lot of attention from the transition department and IDTs as noted above in this section of the report. For one individual, however, some IDT activities delayed the start of the transition activities, ultimately pushing the entire transition to 18 months. This indicator will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	200	114							
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	50% 1/2	0/1	1/1							

Comments:

20. One of two CLDPs met criterion for this indicator.

- Individual #200 was referred on 4/5/16 and transitioned on 10/9/17. The initiation of the referral process was delayed for about six weeks at the outset because the updated behavior plan had not been completed or emailed in a timely manner. Once the profile was completed, transition staff made ongoing efforts to identify potential community homes that could meet Individual #200's needs, particularly as those related to necessary environmental modifications. Many homes that had openings did not have the needed modifications. Despite frequent reminders from transition staff, the IDT did not meet regularly to address this and other possible barriers as required after the 180-day mark had passed. In addition, the IDT did not meet timely to review overnight visits and the transition office was not consistently notified of ISPA meetings related to transition activities. To meet criterion, the respective IDT must be responsive and work collaboratively with transition staff to effect a timely transition.
- Individual #114 was referred on 11/17/16 and transitioned on 3/21/17. This was within 180 days and met criterion

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 within past two years, IPNs from day of admission and first business day after day of admission.
- Behavioral health/psychology monthly progress notes for past six months.
- Current ARD/IEP, and most recent progress note or report card.
- For the past six months, list of all training conducted on PBSP
- For the past six months, list of all training conducted on SAPs
- A summary of all treatment integrity/behavior drills and IOA checks completed for PBSPs.
- A summary of all treatment integrity/behavior drills and IOA checks completed for skill acquisition programs from the previous six months.
- Description/listing of individual's work program or day habilitation program and the individual's attendance for the past six months.
- Data that summarize the individual's community outings for the last six months.
- A list of all instances of formal skill training provided to the individual in community settings for the past six months.
- The individual's daily schedule of activities.
- Documentation for the selected restraints.
- Documentation for the selected 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
PNA	Psychiatric nurse assistant
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PRN	pro re nata (as needed)
PT	Physical Therapy
PTP	Psychiatric Treatment Plan

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