United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

Dates of Onsite Review: October 1-5, 2018

Date of Report: December 28, 2018

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

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

Table of Contents

Background 3
Methodology 4
Organization of Report 5
Executive Summary 5

Status of Compliance with Settlement Agreement
- Domain 1 7
- Domain 2 20
- Domain 3 69
- Domain 4 118
- Domain 5 129

Appendices
- A. Interviews and Documents Reviewed 143
- B. List of Acronyms 151

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.

During the onsite monitoring visit week, a number of serious and dangerous behavioral episodes occurred that involved a number of different individuals. It was evident that the Center had difficulty managing these situations, in part, due to failing to implement immediate emergency protections (e.g., crisis intervention physical restraint, crisis intervention chemical restraint) during imminently dangerous situations (e.g., physical aggression, property destruction, threats of violence, walking out of Center grounds into the busy street).

Direct support professionals, administrative staff, clinicians, family members, and individuals demonstrated or told the Monitoring Team about their concern for their safety and the safety of staff and individuals. Behavioral episodes occurred almost every day.

The Monitor discussed these concerns and issues during the onsite week with the Center Director, the Interim Associate Commissioner for the SSLCs (via telephone), the State Office Discipline Coordinator for Behavioral Health, and attorney representatives from the SSLC State Office and from DOJ. All were receptive to the Monitor's comments, actions were immediately developed, and some were put into place. These actions included special IDT meetings, modifications to behavioral and crisis plans, additional activities for individuals, State Office onsite support (e.g., psychiatry, behavioral health, IDTs/ISPs, administrative), and plans for one individual to have a 30-day psychiatric placement to obtain psychiatric and behavioral stability. Furthermore, State Office planned to play a larger role in oversight and support of the Center.

To that end, State Office and the Center developed an Improvement Plan and will be sending weekly updates to the Monitors and DOJ. The plan included various individual-specific and center-wide actions. In addition, the Monitor requested, for five specific individuals, each month through the full month of January 2019: any updates to PBSPs, CIPs, and/or behavioral assessments; the monthly behavioral health services progress note; any psychiatry notes; and any ISPAs. The Monitor also requested information regarding the Center's follow-up with the concerns of the family of Individual #109. The State agreed to this set of requests.

The Center's challenges were compounded by vacancies (for various reasons) in these positions: Director of Behavioral Health Services, Lead Psychiatrist, Medical Director, Nursing Operations Officer, Dental Director, and Incident Management Coordinator. On the other hand, experienced department directors remained in many of the other departments.

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, were moved to, or were already in, the category of requiring less oversight after the last review. For this review, no additional indicators were moved this category, however, one section (Abuse/Neglect and Incident Management) was deemed to be in substantial compliance by the parties and was exited from 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>
Overall, the rate of crisis intervention restraint over the nine-month period was the lowest at the Center since the Monitoring Team began reporting on rate. There were no occurrences of crisis intervention chemical restraint, mechanical restraint, or protective mechanical restraint for self-injurious behavior.

That being said, there were instances where crisis intervention restraint was warranted due to imminent danger presented by various individuals, for example, Individual #13 (please see comments in the Executive Summary section of this report). Although the Monitor reports on rates of crisis intervention restraint, the Center should never fail to implement crisis intervention restraint when it is needed.

The Center did not correctly implement (or have) a proper protocol for accessing, implementing, and administering crisis intervention chemical restraint (e.g., example observed during the onsite visit for Individual #151).

The Center had recently completed staff training in the SUR and Ukeru programs (the Center reported 97% staff completion at the time of the onsite visit).

Performance on the various indicators of restraint management, documentation, and review met criteria for almost all restraints that were reviewed by the Monitoring Team.

Some of the areas in which nursing staff need to focus with regard to restraint monitoring include: initiating timely assessments, providing follow-up for abnormal vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and completing assessments to determine whether or not individuals sustained injuries.

Abuse, Neglect, and Incident Management

El Paso SSLC was deemed by the parties to have met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management in September 2018. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement). This includes what were indicators 20-23 in previous monitoring reports as well as information on non-serious injury investigations, which was indicator 15 in previous monitoring reports.

Even so, El Paso SSLC will need to attend to protection from harm, incident management, and attention to the elimination of abuse, neglect, and exploitation. As detailed somewhat in the Executive Summary of this report, there were occurrences of violent and self-injurious behaviors occurring on campus without proper supports in place to reduce the risk of harm to other individuals, staff, and the individuals exhibiting the behaviors.

Given that the Center's long-term incident management coordinator (IMC) was leaving the Center as of the Friday of the onsite monitoring week, senior management will need to ensure that the quality of the Center's investigations and reviews remain at criteria.

On a positive note, it was good to see that peer to peer aggression was now being included as part of the Center's regular monthly behavioral health services review meeting.

Other

Prior to the last review, the Center failed to complete Drug Utilization Evaluations (DUEs) no less than quarterly. In the six months prior to this review, the Center completed quarterly DUEs. Center staff are encouraged to continue completing DUEs as required.

Restraint

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

Summary: El Paso SSLC should ensure implementation of crisis intervention restraint when circumstances require it, that is, when there are imminently dangerous circumstances for which the staff need to intervene to protect the individual and others from immediate and serious risk of harm. Overall, usage of crisis intervention restraint was low, though recently ascending at the Center. There were no usages of crisis intervention chemical or mechanical restraint, as well as no usages of protective mechanical restraint for self-injurious behavior (PMR-SIB). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
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.	91% 10/11	1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

1. Twelve sets of monthly data provided by the facility for the past nine months (December 2017 through August 2018) were reviewed. The overall use of crisis intervention restraint at El Paso SSLC was less than at the time of the last review, and showed a stable, but recently increasing trend across the nine-month review period. The census-adjusted rate showed El Paso SSLC about in the middle when compared with the other 12 Centers. There were no occurrences of crisis intervention chemical or mechanical restraints, and there was no usage of protective mechanical restraint for self-injurious behavior (PMR-SIB). The average duration of a crisis intervention physical restraint was just over one minute, one of the shortest average durations in the state.

There were fewer injuries reported during crisis intervention restraint than at the time of the last two or three monitoring reviews. This was good to see, though it was unclear to the Monitoring Team as to whether this represented a change in how injuries were noted in the crisis intervention restraint database or if there were now fewer injuries that occurred during crisis intervention restraint. The number of different individuals who had crisis intervention restraint remained low, at about three to four each month.

The use of interventions to help individuals attend/receive medical and dental treatment remained low for the use of non-chemical restraints (e.g., arm hold) and for pretreatment sedation. TIVA/GA usage remained about the same as at the last review. The Center

had what they called a dental desensitization room for individuals to become more familiar and comfortable with the entire dental treatment experience. This was good to see. However, there was no structure or planned strategies, no data collection, and no assessment of the effects upon individuals or on the Center as a whole (e.g., how many individuals no longer needed pretreatment sedation or TIVA/GA due to the desensitization room usage?).

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 injuries that occurred during crisis intervention restraint, 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).

Restraint reduction committee continued to meet. With the departure of the director of behavioral health services, State Office guidance will likely be needed to help the Center's restraint reduction committee continue to meet its purposes of review of individual and center-wide restraint data and management practices.

2. Two of the individuals reviewed by the Monitoring Team were subject to restraint. In addition, one restraint for Individual #177 and one restraint for Individual #151 were also included in this review. Of these, four received crisis intervention physical restraints (Individual #192, Individual #170, Individual #177, Individual #151). Data from the facility showing frequencies of crisis intervention restraint for the individuals showed low or decreasing trends for three of the four (Individual #192, Individual #177, Individual #151). The other individuals reviewed by the behavioral health Monitoring Team had no occurrences of crisis intervention restraint and were scored positively for this indicator.

Note: Crisis intervention restraint should be used when there are imminently dangerous circumstances for which the staff need to intervene with crisis intervention restraint to protect the individual and others from immediate and serious risk of harm. Although the Monitoring Team looks for decreasing trends in the usage of crisis intervention restraint, appropriate usage of crisis restraint does not prevent the Center from moving forward towards substantial compliance with the protection from harm restraint aspects of the Settlement Agreement. During the onsite week, there were one or more occasions where crisis intervention physical and/or chemical were warranted, but not implemented (e.g., for Individual #13 and for Individual #151).

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 communication skills and engagement in activities. ISP IRRF sections continued to document restraint contra-indications. With sustained high performance, this indicator might be moved to the category of requiring less oversight after the next review. Indicators 9 and 11 will remain in active monitoring. Please see comments below regarding indicator 11 and the need for	Individuals:

more detail in the IRRF.											
#	Indicator	Overall Score	192	170	177	151					
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% 0/1	Not rated	0/1	Not rated	Not rated					
10	Restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
11	The restraint was not in contradiction to the ISP, PBSP, or medical orders.	100% 6/6	2/2	2/2	1/1	1/1					

Comments:
The Monitoring Team chose to review six restraint incidents that occurred for four different individuals (Individual #192, Individual #170, Individual #177, Individual #151). Of these, all four were crisis intervention physical restraints. The individuals included in the restraint section of the report were chosen because they were restrained in the nine months under review, enabling the Monitoring Team to review how the SSLC utilized restraint and the SSLC's efforts to reduce the use of restraint.

9. Because criterion for indicator 2 was met for three of the individuals, this indicator was not scored for them. Criteria for this indicator were not met for Individual #170 because his communication needs were not being met and he was not engaged in activities.

11. There should be, but wasn't, some brief statement in the IRRF indicating that the team considered individualized possible contra-indications for the individual, that is, for example, that the team looked at the active problem list (e.g., how osteoporosis might affect the usage or prohibition of restraint).

Outcome 3- Individuals who are restrained receive that restraint from staff who are trained.	
Summary: Staff correctly answered the Monitoring Team's questions about restraint usage. Given the Center's problems in implementing crisis intervention	Individuals:

restraint when needed, this indicator will remain in active monitoring, but with sustained high performance, might be moved to the category of requiring less oversight after the next review.											
#	Indicator	Overall Score	192	170	177	151					
12	Staff who are responsible for providing restraint were knowledgeable regarding approved restraint practices by answering a set of questions.	100% 1/1	Not rated	1/1	Not rated	Not rated					
Comments:											

Outcome 4- Individuals are monitored during and after restraint to ensure safety, to assess for injury, and as per generally accepted professional standards of care.											
Summary: Overall, restraint monitors arrived and acted as required. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	192	170	177	151					
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	83% 5/6	2/2	2/2	0/1	1/1					
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A	N/A	N/A	N/A	N/A					
Comments: 13. For Individual #177 3/14/18, there was an error in the IRIS form. That is, it showed the restraint monitor arriving two hours prior to the administration of the crisis intervention restraint.											

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: initiating timely assessments, providing follow-up for abnormal vital signs; providing more detailed descriptions of individuals' mental status, including specific comparisons to the individual's baseline; and completing assessments to determine whether or not individuals sustained injuries. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	192	170	177	151					

a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	0% 0/6	0/2	0/2	0/1	0/1					
b.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	17% 1/6	0/2	0/2	1/1	0/1					
c.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	0% 0/6	0/2	0/2	0/1	0/1					

Comments: The restraints reviewed included those for: Individual #192 on 5/29/18 at 9:57 a.m., and 7/2/18 at 3:45 p.m.; Individual #170 on 6/17/18 at 6:04 p.m., and 7/8/18 at 1:07 p.m.; Individual #177 on 3/14/18 at 5:01 p.m.; and Individual #151 on 7/23/18 at 9:12 a.m.

a. through c. As discussed with Center staff and State Office staff while the Monitoring Team was on site, some of the documentation submitted was confusing. For example, for some restraints (e.g., Individual #192 on 5/29/18 at 9:57 a.m., and 7/2/18 at 3:45 p.m.), the documentation showed that nurses obtained full sets of vital signs while the individual was in the restraints.

The following provide examples of problems noted:

- At times, nurses did not document descriptions of individuals' behaviors or their mental status (e.g., Individual #192 on 5/29/18 at 9:57 a.m.), or did not provide needed detail, but rather made statements such as "no changes from baseline" (e.g., Individual #192 on 7/2/18 at 3:45 p.m., Individual #170 on 6/17/18 at 6:04 p.m., and Individual #151 on 7/23/18 at 9:12 a.m.).
- At times, individuals' vital signs were high or low, but nurses did not conduct follow-up (e.g., Individual #192 on 5/29/18 at 9:57 a.m., and Individual #177 on 3/14/18 at 5:01 p.m.).
- Nurses did not always initiate assessments within 30 minutes of the start of the restraint (e.g., Individual #192 on 7/2/18 at 3:45 p.m., and Individual #151 on 7/23/18 at 9:12 a.m.).
- Sometimes, nurses did not conduct complete vital sign assessments without explanation (e.g., Individual #192 on 7/2/18 at 3:45 p.m., Individual #170 on 6/17/18 at 6:04 p.m., and Individual #170 on 7/8/18 at 1:07 p.m.).
- At times, nurses did not document complete skin assessments to confirm whether or not the individual sustained injuries (e.g., Individual #192 on 7/2/18 at 3:45 p.m., and Individual #151 on 7/23/18 at 9:12 a.m.).
- For Individual #170's restraint on 6/17/18 at 6:04 p.m., documentation indicated: "[Individual #170] kept hitting with force his face and head." Based on review of IView and IPNs, nursing staff did not assess him for a potential head injury. In addition, although the IPN, dated 6/17/18, at 8:47 p.m. indicated that he did not have an injury, the related IView documentation did not include a skin assessment, or a pain assessment.
- For Individual #170's restraint on 7/8/18 at 1:07 p.m., documentation indicated: "[Individual #170] was pacing around cottage he was then asked if he wanted to go for a walk, by staff, he then began to hit his head on walls, glass, bite himself, he moved Ukeru pads out of the way to [hit] his head on glass in front of tv, he was then restrained." Nursing staff did not follow standards of care for the assessment for a possible head injury. This was despite the fact that nursing staff administered as needed medication for a headache, and when his pain was reassessed using a FACES scale, he reported a rating of 4, which means "hurts a little more."
- For Individual #177, a Nursing IPN noted a "2.5cm [centimeter] bite break in skin, black and red in color, not active bleeding or

drainage. Cleansed with warm water and soap, Band-Aid placed." The Nursing IPN noted that "resident also mentioned that he was bitten by the other individual while he was in the physical altercation, LT [left] forearm." The nursing IPN did not include information to show that the nurse notified the Nursing Supervisor, or PCP of the human bite. However, a corresponding medical IPN, dated 3/15/18, at 9:58 a.m., referenced the human bite and his other complaints. The next nursing IPN was dated 3/16/18, at 9:49 a.m., regarding a reopened scab. Based on the description of the altercation, elevation of vital signs, skin integrity issues, and human bite by a peer, nurses did not follow standards of care for follow-up assessments and notification of the PCP.

- For Individual #151, his respiratory rate of 28 was high (range 12 to 20), but nursing staff did not conduct follow-up. In addition, although an IPN mentioned a skin assessment, corresponding IView assessment information was not found.

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.

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

Individuals:

#	Indicator	Overall Score	192	170	177	151					
15	Restraint was documented in compliance with Appendix A.	100% 6/6	2/2	2/2	1/1	1/1					

Comments:

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

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

Individuals:

#	Indicator	Overall Score	192	170	177	151					
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	83% 5/6	2/2	2/2	0/1	1/1					
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	100% 6/6	2/2	2/2	1/1	1/1					

Comments:
16. The review process did not detect the time reporting documentation discrepancy noted above in indicator 13.

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

Summary: There were no occurrences of crisis intervention chemical restraint during the review period leading up to the onsite week. During the onsite week, there were occurrences for Individual #13. Moreover, it became evident during the onsite week that the Center did not have working systems in place for individuals to receive crisis intervention chemical restraint when the circumstances warranted it (e.g., incident with Individual #151 in the street). These indicators will remain in active monitoring for possible review at the next onsite visit.			Individuals:								
#	Indicator	Overall Score										
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.											
48	Multiple medications were not used during chemical restraint.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
49	Psychiatry follow-up occurred following chemical restraint.											
Comments:												

Abuse, Neglect, and Incident Management

El Paso SSLC was deemed by the parties to have met substantial compliance criteria with Settlement Agreement provision D regarding abuse, neglect, and incident management in September 2018. Therefore, this provision and its outcomes and indicators were not monitored as part of this review.

Aspects of incident management, occurrences of abuse/neglect, and investigations will remain and/or become part of the Center's quality improvement system and will be reviewed by the Monitoring Team as part of its monitoring of Quality Assurance/Improvement (i.e., section E of the Settlement Agreement). This includes what were indicators 20-23 in previous monitoring reports as well as information on non-serious injury investigations, which was indicator 15 in previous monitoring reports.

Pre-Treatment Sedation

Outcome 6 – Individuals receive dental pre-treatment sedation safely.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	If individual is administered total intravenous anesthesia	0%	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

Comments: a. As discussed in the last report, 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 the use of TIVA with Individual #187 on 6/13/18, informed consent for the TIVA was present, nothing-by-mouth status was confirmed, and nurses completed post-operative vital sign assessments, as required. However, the dental note did not provide sufficient information. Comments related to four quadrants of gum treatment were vague. The entire treatment note was seven lines for this individual who had three restorations completed. The actual technical note provided no information related to the restorations. The note provided no information related to whether or not the dentist assessed the individual prior to anesthesia or the condition of the individual at the time the procedure was completed.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals the Monitoring Team responsible for the review of physical health reviewed were administered oral pre-treatment sedation for dental procedures.

Outcome 11 – Individuals receive medical pre-treatment sedation safely.											
Summary: This indicator will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	If the individual is administered oral pre-treatment sedation for medical treatment, proper procedures are followed.	100% 1/1	N/A	1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. For Individual #170, who received oral pre-treatment sedation for an off-campus appointment on 2/5/18, staff followed proper procedures.

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: El Paso SSLC IDTs were discussing some aspects of pretreatment	Individuals:

sedation and/or general anesthesia during the annual meeting. Plans identified as informal were described to the Monitoring Team. They were not, however, based upon individual needs/issues and they were not in proper format, without which it would be unlikely for positive effects to occur. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	0% 0/6		0/1	0/1	0/1		0/1	0/1	0/1	
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	100% 6/6		1/1	1/1	1/1		1/1	1/1	1/1	
3	If treatments or strategies were developed to minimize or eliminate the need for PTS, they were (a) based upon the underlying 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.	17% 1/6		1/1	0/1	0/1		0/1	0/1	0/1	
4	Action plans were implemented.	100% 6/6		1/1	1/1	1/1		1/1	1/1	1/1	
5	If implemented, progress was monitored.	0% 0/6		0/1	0/1	0/1		0/1	0/1	0/1	
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	N/A		N/A	N/A	N/A		N/A	N/A	N/A	

Comments:
This outcome and its indicators applied to Individual #192, Individual #170, Individual #108, Individual #187, Individual #134, and Individual #198.

1. There was documentation for some, but not all, of the required sub-indicator content for this indicator. All individuals had a rationale for general anesthesia (GA) use prior to dental procedures, which included uncooperative and disruptive or dangerous behavior when dental procedures were attempted without GA. Additionally, all individuals had documentation of supports/interventions to prevent the future use of restraint, which consisted of increasing toothbrushing and visits to the desensitization clinic.

Only Individual #170 had documentation of informed consent for GA. None of the individuals had documentation of GA usage over the past year, or risks/benefits of GA.

2 and 4. There was evidence of action plans for desensitization clinic visits and/or regular toothbrushing to reduce the usage of GA. 3. Individual #192's treatment strategies were based upon the hypothesized cause, in his ISPA, and written as a service objective (SO). The other individuals' treatment strategies were not written as a SAP, SO, or IHCP. 5-6. There was no documentation of action plan data for any individuals and, consequently, no determination of progress or no progress.

Mortality Reviews

Outcome 12 – Mortality reviews are conducted timely, and identify actions to potentially prevent deaths of similar cause, and recommendations are timely followed through to conclusion.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score									
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	N/A									
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	N/A									
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	N/A									
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	N/A									
e.	Recommendations are followed through to closure.	N/A									
Comments: a. Based on documentation submitted, since the last review, no individuals the Center supported had died.											

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 Center staff reported for an individual in the review group, Center staff followed the correct process.	Individuals:

#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	ADRs are reported immediately.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1/1	N/A
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. As part of the QDRR process, on 3/2/18, the Clinical Pharmacist noted Individual #177 had an abnormal lab value showing thrombocytopenia, and reported it as a potential ADR. The practitioner already had tapered off and discontinued the use of Divalproex due to metabolic issues.											

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: These indicators will continue in active monitoring.		Individuals:
#	Indicator	Score
a.	Clinically significant DUEs are completed in a timely manner based on the determined frequency but no less than quarterly.	100% 2/2
b.	There is evidence of follow-up to closure of any recommendations generated by the DUE.	100% 2/2

Comments: a. and b. At the time of the last review, these indicators returned to active oversight, because the Center failed to complete DUEs no less than quarterly.

In the six months prior to the current review, El Paso SSLC completed two DUEs, including:

- A DUE on oral antihistamines that was presented to the Pharmacy and Therapeutics (P&T) Committee on 6/20/18. Minutes documented follow-up action; and
- A DUE on Corticosteroids that was presented to the P&T Committee on 3/21/18. Minutes documented follow-up action.

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, 10 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, an additional five indicators were also moved to this category, in the areas of psychiatry, behavioral health, and skill acquisition. On the other hand, one indicator, in medical, was returned to the 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.

There was no on-campus psychiatrist available during the onsite review week. State Office was providing some support and there were plan for a locum tenens provider to begin soon.

There was an interim director of behavioral health services.

Assessments

IDTs considered what assessments the individual needed prior to the annual ISP meeting (as documented in the ISP preparation meeting) for all individuals. But then, IDTs did not arrange for and obtain all of these needed, relevant assessments prior to the meeting.

For the individuals' risks reviewed, IDTs continued to struggle to effectively use supporting clinical data (including comparisons from year to year), use the risk guidelines when determining a risk level, and/or as appropriate, provide clinical justification for exceptions to the guidelines. As a result, for 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.

Regarding annual psychiatry update assessments, overall, there was improved performance in that documentation was submitted to the ISP timely and it was complete for all but one individual. Furthermore, the psychiatrist attended many ISP meetings.

Criteria for annual behavioral health assessments were met for all individuals. Some attention to content of functional assessments remained a need.

In skill acquisition, all individuals had FSAs. Some assessments, however, were not available for IDT usage in a timely manner. About one-third of individuals' vocational assessments did not include recommendations for SAPs, or a rationale for why a SAP recommendation was not made.

Based on the Monitoring Team's review of annual medical assessments for review of other indicators, PCPs completed 33% of them late. At the time of the last review, similar issues existed. As a result, the related indicator will return to active oversight.

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

It was good to see that for the individuals reviewed, the Dental Department completed timely annual dental summaries. The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams, particularly with regard to treatment plans, as well as dental summaries.

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

Some improvement was seen with regard to the timeliness of referrals to the Physical and Nutritional Management Team (PNMT), and the timeliness of the PNMT's reviews. The Center should focus on sustaining its progress in these areas, as well as completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.

The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. Although some improvement was noted, the quality of OT/PT assessments continues to be an area on which Center staff should focus.

Since the last review, it appeared the Center took steps to address the concerns previously identified in relation to providing individuals with comprehensive assessments at least every three years, unless clear clinical justification is provided for not doing so. However, significant work is needed to improve the quality of communication assessments and updates.

Individualized Support Plans

The Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility's response to incidents. In most cases, the facility reviewed incidents and assigned follow-up action for staff to complete to ensure any contributing factors identified were addressed. The format of the two daily morning unit meetings (led by the unit director) ensured that team members were all made aware of any incidents, status changes, and changes in supports. This allowed for quick follow up to incidents.

It was evident, through interviews and observations throughout the week, that QIDPs and direct support professionals (DSPs) knew the individuals whom they supported well. They were aware of their risks, familiar with their support plans, and interactions were supportive and positive. QIDPs were very knowledgeable regarding individuals on their caseload.

Overall, the cottages were personalized, clean, and well maintained.

The number of goals that met criteria for indicator 1 continued to decrease, that is, from 23 to 18 to 12 over the past three reviews. This indicated that QIDPs and IDTs must do more to identify goals that are individualized and meaningful for individuals. A positive, however, was that most goals that met criteria with indicator 1 were written in measurable terminology. But, for only one were there reliable data collected.

Work and day goals were not meaningful or functional. Rather than being aspirational or providing opportunities to learn new skills, day goals typically related to compliance with attending solely the on-campus day or work sites.

Regarding the IDT's discussion and consideration of various living options, almost all of the indicators scored lower than at the last review (indicators 19-29). El Paso SSLC has a history of supporting decision-making around community living options. The QIDP department might benefit from input from the Admissions Placement department staff.

For two-thirds of the individuals, one or more important members of the IDT did not attend the annual ISP meeting.

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 plans of care.

Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included many necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable.

In psychiatry, over the nine-month review period, the El Paso SSLC psychiatry department much progress in that, for most individuals, psychiatric indicators for reduction were identified in one or more documents, the indicators were consistently identified, and they were defined in observable terminology. Regarding indicators for increase (i.e., positive/desirable behaviors that indicate the individual's condition, or ability to manage the condition is improving), there remained a need for these indicators to be consistent with the individual's diagnoses.

In behavioral health, all individuals who needed a PBSP had one. Individuals had goals that were relevant and measurable. Most goals were based on assessments, but not all. PBSPs were current and about half contained all of the required components.

Data were shown to be reliable for more individuals than ever before. This is a requirement for making good treatment decisions, especially given the recent behavioral and psychiatric challenges presented by many individuals.

As anticipated since the last review, performance in SAPs improved. More were measurable, based on assessments, and meaningful. One-quarter had reliable data. More work is needed, but it was good to see progress occurring. One individual did not have any SAPs and many of the other individuals had only a few, even though they had many skill development needs and would have benefited from additional SAPs.

ISPs

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.												
Summary: The number of goals that met criteria for indicator 1 continued to decrease, that is, from 23 to 18 to 12 over the past three reviews. This indicates that QIDPs and IDTs must do more to identify goals that are individualized and meaningful for individuals. Most goals that met criteria with indicator 1 were written in measurable terminology, though only for one were there reliable data collected. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	170	69	187	155	32			
1	The ISP defined individualized personal goals for the individual based on the individual's preferences and strengths, and input from the individual on what is important to him or her.	0% 0/6	2/6	2/6	2/6	3/6	1/6	2/6			
2	The personal goals are measurable.	0% 0/6	1/6	2/6	2/6	3/6	1/6	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	1/6	0/6	0/6	0/6	0/6			
Comments: The Monitoring Team reviewed six individuals to monitor the ISP process at the facility: Individual #170, Individual #187,												

Individual #135, Individual #69, Individual #32, and Individual #155. 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 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.

IDTs were struggling to develop good vision statements for individuals. This led to the development of goals with no clear purpose or priority for the individual. Rarely were goals aspirational. In particular, work and day goals were not meaningful or functional. Rather than being aspirational or providing opportunities to learn new skills, day goals typically related to compliance with attending solely the on-campus day or work sites.

None of the six individuals had individualized goals in all six goal areas. Therefore, none had a comprehensive set of goals that met criterion.

For this set of 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, 12 of 36 personal goals met criterion for this indicator. This was a decrease from the last review when 18 goals met criterion. Goals that met criterion were:

- Individual #170's goals for recreation and living options.
- Individual #187's goals for recreation, greater independence, and living options.
- Individual #135's goals for relationships and living options.
- Individual #69's goals for relationships and living options.
- Individual #32's goal for relationships and living options.
- Individual #155's living options goal.

Although IDTs had created the above goals (that were more individualized and based on known preferences), few had specific teaching strategies to ensure staff were implementing them and measuring success consistently, additionally, 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.

Individual #134's ISP meeting was observed. The IDT failed to develop a vision for Individual #134 that would lead to greater independence and a more meaningful life based on his preferences. New goals suggested by the team were based on compliance with facility expectations and increasing participation in activities that were already available to him. For instance, the IDT proposed a goal

to learn three songs on his keyboard. He currently spent much of his time playing on his keyboard. This activity was not likely to lead towards greater independence. His proposed work/day goal centered around compliance with attending the workshop. He received rewards for showing up at the workshop over the previous year, however, he rarely met this goal and the team did not document his response to work opportunities. The IDT did not discuss what type of work might be meaningful to him and/or what work skills he might learn at the workshop.

2. Of the 12 personal goals that met criterion for indicator 1, 10 also met criterion for measurability. The two that did not were Individual #135's and Individual #32's relationship 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. One 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. This was Individual #170's recreation/leisure goal.

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 Center. 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.

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

Summary: Performance on this set of indicators was slightly less than the low scores in the last review. 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: 135	170	69	187	155	32			
8	ISP action plans support the individual's personal goals.	0% 0/6	1/6	0/6	1/6	0/6	0/6	0/6			
9	ISP action plans integrated individual preferences and opportunities for choice.	0% 0/6	0/1	0/1	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
12	ISP action plans integrated strategies to minimize risks.	0%	0/1	0/1	0/1	0/1	0/1	0/1			

		0/6									
13	ISP action plans integrated the individual's support needs in the areas of physical and nutritional support, communication, behavioral health, health (medical, nursing, pharmacy, dental), and any other adaptive needs.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
14	ISP action plans integrated encouragement of community participation and integration.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	17% 1/6	0/1	0/1	0/1	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	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:

8. Twelve 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.

Two of the goals had action plans that were likely to lead to the accomplishment of the goal. Individual #135's action plans to support his living option goal, and Individual #69's relationship goal had reasonable action plans to support these goals.

For the most part, though, IDTs were not developing action steps that would lead to measurable progress towards goals. Although the facility acknowledged that IDTs needed additional training on developing action plans to support goals at the last review, there had been no identifiable progress in developing action plans to support goals.

Skill acquisition programs did not include enough information to ensure that staff could consistently implement them and determine what progress was made. Most of the action plans were written as service objectives and did not include staff instructions or implementation strategies that would ensure staff could consistently teach a new skill or accurately collect data on progress.

9. None of the ISPs had action plans that integrated preferences and opportunities for choice. IDTs were not identifying preferences in a way that might guide the development of activities that would offer opportunities to learn new skills and build on developing a plan for meaningful days. For the most part, ISPs listed general preferences related to food, music, TV, and activities routinely offered at the facility.

Individuals were rarely offered opportunities to make choices and for those action plans that did offer choices, choices were limited, rarely meaningful, and unlikely to lead towards greater independence. For example, Individual #155 had an action plan to select an activity to engage in during leisure time. Staff reported that she was usually offered brightly colored Legos and another type of blocks or manipulatives. Expanding choices may result in discovering new preferences.

10. None of the ISPs clearly addressed strengths, needs, and barriers related to informed decision-making. A basis to making informed decisions is offering individuals exposure to a variety of new experiences and opportunities to make choices throughout their day. These opportunities were rarely included in action plans in any substantial way.

11. None of the ISPs met criterion for this indicator to support the individual's overall independence. Assessments and interviews indicated that many of the action plans were compliance plans written for skills that the individual could already complete independently.

12. None of the ISPs integrated strategies to minimize risks in ISP action plans. While risks were addressed through action plans included in the IHCP, supports were not integrated into other action plans when relevant, and risks were not always identified by the IDT. Rarely were SAPs written to provide staff with strategies for implementing plans and, when SAPs were written, they did not include specific mobility, behavioral, and safe eating supports.

Some findings related to identification of risks included:

- Individual #170's dental exam noted that he had poor oral hygiene. His last comprehensive dental exam was in 2015. Dental supports were not integrated into his ISP.
- Individual #135's ISP did not document discussion of his GI and other health risks related to polypharmacy.
- Individual #69 recently moved back to the facility after his community placement failed due to behavioral risks. His living option discussion did not define behaviors that were a barrier to living in a less restrictive environment.

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. Some examples of this lack of integrated supports included:

- Individual #69's action plans and SAPs did not integrated recommendations from his medical, behavioral, and communication assessments.
- Individual #32's ISP included a recommendation for an assessment by his OT and BHS to develop a SAP related to his goal to feed himself. His QIDP monthly review indicated that the SAP was developed without completion of this assessment. His action plan to walk with staff to the van did not include behavior or PT supports.
- Individual #187's goal to use her call bell to let staff know that she wanted to get out of bed was not functional. It was not evident that her SLP was involved in developing/supporting SAPs to ensure that this goal was functional for communication. Her IEP goals were not integrated into action plans.
- Individual #155's action plan to purchase clothes in the community did not include mobility/positioning or communication

supports. Her recreation goal to communicate her preferred activity did not include support strategies from her communication assessment.

14. Meaningful and substantial community integration action plans were absent from the ISPs for these individuals, with no specific, measurable action plans for community participation that promoted any meaningful integration.

Individuals made frequent trips into the community, but were rarely given opportunities to utilize community resources that might support them to be more independent and integrated into the community. Individuals did not have goals for banking, volunteering, getting haircuts, joining a church, or joining a gym in the community. Outings were limited to specific events, such as eating out, going to the movie, or attending a sporting event. While these types of activities support community exposure, they are unlikely to lead to meaningful integration.

15. One ISP included action plans to support opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs. This was Individual #187's goal to attend school in the community. Day and work opportunities were particularly limited for most individuals. Vocational training was not focused on building skills that might lead towards employment in a more integrated setting.

Training opportunities were limited and rarely individualized. Individuals had few opportunities to learn new skills and experience new things. Individual #170, Individual #32, and Individual #155 did not spend a majority of their day outside of their homes engaged in meaningful programming.

Across the Center, one individual was reported to be working in the community one day per week at Wendy's restaurant. Ten other individuals were employed in on-campus jobs for varying numbers of hours per week.

16. For the most part, ISPs did not support substantial opportunities for functional engagement described with sufficient frequency, duration, and intensity throughout the day to meet personal goals and needs. Overall, the ISPs provided limited opportunities for learning and functional skill development. During observations, activities were rarely functional and did not provide opportunities to experience new things and learn new skills. IDTs need to expand the preference assessment to offer more opportunities to try new things and identify new interests. Individual #187 attended school during the day. Individual #135 worked in the facility kitchen, however, his ISP action plans did not define his work day and did not include action plans for skill building related to his job.

17. ISPs did not adequately address barriers to achieving goals and learning new skills. Goals were not consistently implemented, and IDTs did not address barriers to implementation. A review of ISP preparation documents indicated that some goals that either had not been implemented or the individual failed to make progress were continued from the previous ISP without addressing barriers.

18. Action plans did not describe detail about data collection and review, in almost all cases. 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, not individualized, 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: Almost all of the indicators scored lower than at the last review. El Paso SSLC has a history of supporting decision-making around community living options. The QIDP department might benefit from input from the Admissions Placement department staff. These indicators will remain in active monitoring (indicator 20 will remain in less oversight).			Individuals:								
#	Indicator	Overall Score	135	170	69	187	155	32			
19	The ISP included a description of the individual's preference for where to live and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities).	50% 3/6	0/1	1/1	1/1	0/1	1/1	0/1			
20	If the ISP meeting was observed, the individual's preference for where to live was described and this preference appeared to have been determined in an adequate manner.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
21	The ISP included the opinions and recommendation of the IDT's staff members.	33% 2/6	1/1	1/1	0/1	0/1	0/1	0/1			
22	The ISP included a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR.	80% 4/5	1/1	1/1	1/1	0/1	1/1	N/A			
23	The determination was based on a thorough examination of living options.	17% 1/6	0/1	0/1	1/1	0/1	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).	17% 1/6	0/1	0/1	0/1	0/1	1/1	0/1			
25	For annual ISP meetings observed, a list of obstacles to referral was identified, or if the individual was already referred, to transition.	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.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
27	For annual ISP meetings observed, the IDT developed plans to address/overcome the identified obstacles to referral, or if the individual was currently referred, to transition.	0% 0/1	N/A	N/A	N/A	N/A	N/A	N/A			
28	ISP action plans included individualized-measurable plans to educate the individual/LAR about community living options.	0% 0/4	N/A	0/1	N/A	0/1	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. Three ISPs included a description of the individual's preference for where to live and how that preference was determined by the IDT.

- Individual #170 and Individual #155's described living option preferences based on observations and staff knowledge.
- Individual #69 had recently moved from the community, so was familiar with living options. He told the IDT that he would like to return to living in the community.

21. Two ISPs included the opinions and recommendation of the IDT's staff members.

- Individual #187 and Individual #32's annual medical assessment did not include a recommendation or were not completed until after the ISP meeting and the PCP did not attend the ISP meeting.
- Individual #69 and Individual #155's nursing assessment did not include a recommendation.

22. Four of five ISPs documented the overall decision of the IDT as a whole, inclusive of the individual and LAR. Individual #187's ISP did not include a clear summary statement regarding the living options discussion.

23. One of the individuals (Individual #69) had a thorough examination of living options based upon their preferences, needs, and strengths. For the most part, ISPs did not document discussion regarding placement options that might support current support needs, preferences, and strengths.

24. One ISP 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 #155's ISP identified her guardian's wishes as a barrier. The other ISPs noted that behavioral needs were barriers to community living options, however, specific behaviors that could not be supported in the community were not identified.

25 and 27. The Monitoring Team attended the annual ISP meeting for Individual #79. The IDT identified her psychiatric instability as an obstacle to referral. How an improvement in her psychiatric condition would relate or impact a possible referral was not discussed.

26. None of the individuals had individualized, measurable action plans to address obstacles to referral, or were referred if obstacles were not identified. As noted, barriers were not clearly defined by the IDTs. Action plans did not include measurable criteria for identifying progress towards the goal.

28. Four individuals did not have individualized and measurable action plans to educate the individual and/or LAR on living options that might be available to support their needs. Individual #135 and Individual #69's ISPs indicated that they had recently lived in the community and were aware of living options.

29. None of the individuals had been referred to the community.

Outcome 5: Individuals' ISPs are current and are developed by an appropriately constituted IDT.												
Summary: Ensuring individual and IDT member participation in the annual ISP process is essential for creating an individualized comprehensive ISP. These three indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	135	170	69	187	155	32				
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).	33% 2/6	1/1	0/1	0/1	0/1	1/1	0/1				
34	The individual had an appropriately constituted IDT, based on the individual's strengths, needs, and preferences, who participated in the planning process.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1				

Comments:

32. Documentation was not submitted that showed that action plans were implemented within a timely basis for any of the individuals.

33. Two individuals (Individual #135, Individual #155) attended their ISP meetings. The facility needs to ensure that individuals are meaningfully engaged in the ISP development process.

34. Two of the individuals had an appropriately constituted IDT (Individual #170, Individual #69), based on the individual's strengths, needs, and preferences, who participated in the planning process.

- Individual #187's SLP did not attend her meeting. She had communication goals. The SLP's input would have been beneficial when developing action plans to support these goals.
- Individual #135's PCP did not attend his IDT meeting and did not provide input into his plan.
- Individual #32's PCP did not attend his ISP meeting and his annual medical assessment was not provided to the IDT prior to his meeting.
- Individual #155's PCP and SLP did not attend her ISP meeting.

Overall, QIDPs and other team members had little expectation for growth or greater independence. The IDT members were not tracking specific progress towards goals or addressing barriers when individuals were not making progress.

IDTs need a better understanding of the ISP process and how to develop a good vision statement, then how to support individuals to achieve that vision.

Outcome 6: ISP assessments are completed as per the individuals' needs.											
Summary: It was good to see that IDTs considered and determined what assessments were needed. Many of these various assessments, however, were not obtained or were submitted late. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	170	69	187	155	32			
35	The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	100% 4/4	N/A	1/1	N/A	1/1	1/1	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. IDTs 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. The two individuals admitted in the past year did not have an ISP preparation meeting.

36. IDTs did not arrange for and obtain all needed, relevant assessments prior to the IDT meeting.
    - Individual #170's last comprehensive dental exam was in 2015. His preference assessment, vocational assessment, and communication assessment were not adequate for planning. The IDT needs to consider more comprehensive assessments that will identify additional interests and skills that might lead towards a more meaningful day program. He currently spent most of his day in his home minimally engaged.
    - Individual #187's annual medical exam was not submitted at least 10 days prior to her ISP meeting. The IDT should consider requesting an additional communication assessment. Her ISP included conflicting recommendations and action plans related to communication.
    - Individual #135's nursing assessment and SLP assessment were submitted after his ISP meeting. His FSA was not submitted 10 days prior to his ISP meeting.
    - Individual #69's behavioral assessment, nursing assessment, and his FSA were submitted late. His vocational assessment was not adequate for planning.
    - Individual #32's annual medical assessment was submitted late. He has not had a vision exam since 2015. His last DEXA scan was completed in 2011. His last comprehensive dental exam was in 2015.
    - Individual #155's annual medical exam and nursing exam were submitted late. Her last comprehensive dental exam and cleaning were in 2015. She also would benefit from a more comprehensive preference assessment to identify new interests that might lead towards more meaningful day programming.
    - In all cases, vocational assessments were not adequate for determining skills and interests that might relate to employment other than what was available at the facility.

Without relevant assessments for the IDT to review, it is unlikely that comprehensive supports and services were developed, and all

risks were addressed.

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

Summary: IDTs met regularly and often. Incidents were often met with follow-up action (see Incident Management section in domain 1 of this report). IDTs, however, did not use data, or revise goals when needed. QIDP monthly reviews were occurring, but work needs to be done to improve the quality (e.g., use of data, analysis of data and inputs). These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	135	170	69	187	155	32			
37	The IDT reviewed and revised the ISP as needed.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
38	The QIDP ensured the individual received required monitoring/review and revision of treatments, services, and supports.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:

37. IDTs met routinely to review supports, services, and serious incidents. This was good to see, however, reliable and valid data were rarely available to guide decision-making. IDTs did not routinely revise goals when progress was not evident.

On a positive note, the Monitoring Team attended a number of meetings while onsite to review the IDT process and the facility's response to incidents. In most cases, the facility reviewed incidents and assigned follow-up action for staff to complete to ensure any contributing factors identified were addressed. The format of the daily unit meetings ensured that team members were all made aware of any incidents, status changes, and changes in supports. This allowed for quick follow up to incidents.

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.

For the most part, monthly reviews were routinely submitted on time and included a cursory review of all services. The consistent completion of the QIDP monthly reviews was good to see, however, they included little meaningful information regarding progress towards goals and efficacy of supports. When additional assessments were recommended throughout the ISP year, it was often not apparent that the IDT obtained those assessments, reviewed any resulting recommendations, and/or implemented changes to supports when recommended.

Some QIDP monthly reviews included data for some action plans, but rarely 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. This practice places individuals at significant risk for harm when the IDT cannot determine if supports to address risks are consistently

implemented or 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: 187	170	32	118	155	58	115	177	107
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	2/2	0/2	1/2	1/2	0/2	2/2	1/2	1/2	0/2

Comments: For nine individuals, the Monitoring Team reviewed a total of 18 IRRFs addressing specific risk areas [i.e., Individual #187 – seizures, and choking; Individual #170 – constipation/bowel obstruction, and infections; Individual #32 – gastrointestinal (GI) problems, and cardiac problems; Individual #118 – dental, and constipation/bowel obstruction; Individual #155 – aspiration, and falls; Individual #58 – infections, and GI problems; Individual #115 – respiratory compromise, and circulatory; Individual #177 – weight, and diabetes; and Individual #107 – GI problems, and skin integrity].

a. When determining risk levels, none of the IDTs effectively used supporting clinical data. Most appeared to use the risk guidelines when determining a risk level, but they did not, as appropriate, provide clinical justification for exceptions to the guidelines.

b. For the individuals the Monitoring Team reviewed, it was positive that the IDTs 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 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 #187 – seizures, and choking; Individual #32 – cardiac problems; Individual #118 – dental; Individual #58 – infections, and GI problems; Individual #115 – circulatory; and Individual #177 – weight.

Psychiatry

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: At El Paso SSLC, there was much progress in many of the sub-indicators of each of the indicators in this outcome. Specifically, El Paso SSLC made progress in that, for most individuals, psychiatric indicators for reduction were identified in one or more documents, the indicators were consistently identified, and were defined in observable terminology. Regarding indicators for increase (i.e., positive/desirable behaviors that indicate the individual's condition, or ability to manage the condition is improving), there remained a need for these indicators to be consistent with the individual's diagnoses. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	0% 0/8	1/2	1/2	1/2	1/2	1/2	1/2		1/2	1/2
5	The individual has goals related to psychiatric status.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
6	Psychiatry goals are documented correctly.	0% 0/8	0/2	0/2	0/2	0/2	0/2	0/2		0/2	0/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	88% 7/8	2/2	2/2	2/2	0/2	2/2	2/2		2/2	2/2

Comments:
The scoring in the above boxes have a denominator of 2, which is comprised of whether criteria were met for all sub-indicators for psychiatric indicators/goals for (1) reduction and for (2) increase.

Note that there are various sub-indicators. All sub-indicators must meet criterion for the indicator to be scored positively.

At El Paso SSLC, there was much progress in many of the sub-indicators.

4. Psychiatric indicators:
A number of years ago, the State proposed terminology to help avoid confusion between psychiatric treatment and behavioral health services treatment, although the two disciplines must work together in order for individuals to receive comprehensive and integrated clinical services, and to increase the likelihood of improvement in 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 maintained.

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 measured via recordings of occurrences of indicators directly observed by SSLC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder.

The Monitoring Team looks for:

a. The individual to have at least one psychiatric indicator related to the reduction of psychiatric symptoms and at least one psychiatric indicator related to the increase of positive/desirable behaviors that indicate the individual's condition (or ability to manage the condition) is improving. The indicators cannot be solely a repeat of the PBSP target behaviors.
b. The indicators need to be related to the diagnosis.
c. Each indicator needs to be defined/described in observable terminology.

El Paso SSLC showed progress in this area in that all individuals had one or more indicators related to the reduction of psychiatric symptoms that related to their psychiatric diagnosis or diagnoses. For example, Individual #187 had a diagnosis of Pervasive Developmental Disorder, Autistic Type. The psychiatric indicator was identified as agitation. The indicator was well defined and described by the psychiatrist.

In general, the psychiatric indicators identified were similar to those identified as target behaviors by behavioral health staff for the PBSPs. In another example, regarding Individual #198, psychiatric diagnoses included Attention Deficit Hyperactivity and Intermittent Explosive Disorder. Psychiatric indicators were aggression and inability to sit still/focus on activities. These indicators were defined. In examples, such as this, where there are rating scales normed for individuals with developmental disabilities, rating scales could be considered.

In general, the psychiatric indicators were well defined with descriptive information for staff. For example, in the case of Individual #181, the psychiatric indicator was noted to be hallucinations associated with Bipolar Mood Disorder. The indicator hallucination was defined as "bipolar disorder...may be complicated by psychotic features such as hallucinations... defined as... stating he sees snakes, rats."

All of the individuals had psychiatric indicators for increase in positive/desirable actions. The indicators were generally the replacement behaviors identified by behavioral health staff. It was not clear, however, how the identified psychiatric indicators for increase related to the individual's diagnosis. For example, for Individual #181, the psychiatric indicator for increase was participation and asking for a break. This was described as "[when he] starts a conversation, he will greet others without cursing or taunting while

making eye contact or waits to talk with others in a calm voice and calm face." Even though this may be an important skill for him to learn and exhibit, and even if it may be an appropriate replacement behavior for a PBSP target behavior, it is not clearly related to the diagnosis of Bipolar Mood Disorder. To meet this part of the criteria, there should be a rationale about how the positive/desirable action relates to the diagnosis when the action it is not immediately evident.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for all eight individuals. For psychiatric indicators for increase, criteria were met for sub-indicator a for all eight individuals, for no individuals for sub-indicator b, and for six individuals for sub-indicator c.

5. Psychiatric goals:
The Monitoring Team looks for:

d. A goal is written for the psychiatric indicator for reduction and for increase.
e. The type of data and how/when they are to be collected are specified.

At El Paso SSLC, there were goals written regarding psychiatric indicators for reduction and for increase. Goals included the psychiatric indicator and a criterion (sub-indicator d). There were no notations regarding what type of data were to be collected (sub-indicator e). The indicators were, in most cases, identical to the behavioral health PBSP target behaviors, so it could be assumed that the indicators would be documented in care tracker. Again, as the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators with goals and the use of rating scales could be considered.

6. Documentation:
The Monitoring Team looks for:

f. The goal to appear in the ISP in the IHCP section.
g. Over the course of the ISP year, goals are sometimes updated/modified, discontinued, or initiated. If so, there should be some commentary in the documentation explaining changes to goals.

At El Paso SSLC, psychiatric indicators/goals for reduction or increase were not incorporated into the Center's overall documentation system, the IHCP. As the goals were not in the IHCP, they were not part of the ISP and QIDP monthly reviews.

7. Data:
Reliable and valid data need to be available so that the psychiatrist can use the data to make treatment decisions. Data are typically 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 regarding psychiatric goals/indicators, psychiatrists often utilize behavioral health services target/replacement behavior data as supplemental information when making treatment decisions.

At El Paso SSLC, data were reported for psychiatric indicators for seven of the eight individuals (the exception was Individual #108). The behavioral health services department reported on data reliability for psychiatric indicators and these data were shown to be reliable (see indicator 5 in the psychology/behavioral health section of this report).

Even so, data regarding Individual #192 were somewhat confusing. There were data reported regarding suicide attempts and self-injurious behavior. Suicide attempts were a target behavior for behavioral health, defined as "attempts to harm himself using objects, (e.g., swallowing glass)." There was a psychiatric indicator of suicide attempts, which were defined as "physical acts to end his life." There were data indicating suicide attempts in March 2018 and May 2018. Even so, there was documentation indicating that he was stable from a psychiatric standpoint.

The ongoing collection and presentation of reliable data is an area of focus for the psychiatry department. Likely, maintaining this will require ongoing collaborative work between psychiatry, behavioral health, residential services, day/vocational services, and the Center's ADOP. This will be the case as El Paso SSLC moves towards further individualizing psychiatric indicators for decrease and increase that may not be identical to what is already being measured by the PBSP as target behaviors.

Summary: El Paso SSLC made progress in that, for most individuals, psychiatric indicators for decrease were identified in one or more documents, the indicators were consistently identified, and were defined in observable terminology. The next steps would be including the goals in the IHCP section of the ISP and ensuring reliable and consistent data collection regarding the indicators. Regarding indicators for increase or positive/desirable behaviors that indicate the individual's condition (or ability to manage the condition) is improving; there is a need for review and of these indicators to ensure that the indicators are consistent with the individual's diagnoses and reflect an improvement in symptom experience.

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.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
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.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		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.	25% 1/4	0/1	0/1	N/A	N/A	1/1	N/A		0/1	N/A
16	All psychiatric diagnoses are consistent throughout the different	75%	0/1	1/1	1/1	1/1	1/1	1/1		1/1	0/1

	sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	6/8									

Comments:

14. The Monitoring Team looks for 14 components in the CPE. None of the CPEs included the required components. The evaluations were missing one to three elements. Five evaluations were missing one element, one evaluation was missing two elements, and two evaluations were missing three elements. The most common missing element was the information regarding the physical examination. This was missing in five examples.

15. For the four individuals admitted in the two years prior to the onsite review, all had a CPE performed within 30 days of admission. Regarding the other required information, Individual #135 did not have an IPN documented by nursing by the first business day after admission. Individual #192 did not have an IPN documented by primary care by the first business day after admission. Individual #198 did not have an IPN documented by primary care by the first business day after admission.

16. There were two individuals whose documentation revealed inconsistent diagnoses across disciplines, Individual #135 and Individual #181.

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

Summary: Overall, there was improved performance on this outcome. Documentation was submitted to the ISP timely and, with sustained high performance, indicator 19 might be moved to the category of requiring less oversight after the next review. The annual psychiatry documentation was complete for all but one individual, and the psychiatrist attended many ISP meetings; both of these were improvements. These four indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
17	Status and treatment document was updated within past 12 months.	Due to the Center's sustained performance, these indicators were 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).	84% 5/6	N/A	1/1	1/1	1/1	N/A	1/1		0/1	1/1
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.	100% 8/8	1/1	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.	75% 6/8	1/1	1/1	1/1	1/1	1/1	0/1		1/1	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	0/1	0/1	0/1	0/1	0/1		0/1	0/1

Comments:
18. The Monitoring Team scores 16 aspects of the annual evaluation document. In general, these evaluations were thorough and contained a large amount of information. This was good to see. The annual evaluations regarding five individuals contained all of the required elements. The evaluation regarding Individual #198 was missing one element: past pharmacotherapy.

19. All individuals requiring an annual CPE had one completed prior to the annual ISP meeting.

20. The psychiatrist attended the ISP meeting for six of the individuals in the review group.

If the psychiatrist does not participate in the ISP meeting, there needs to be some documentation that the psychiatrist participated in the decision to not be required to attend the ISP meeting; this can be by the psychiatrist attending the ISP preparation meeting, or by some other documentation/note that occurs prior to the annual ISP meeting. Even so, in the three-month period between the ISP preparation meeting and the annual ISP meeting, the status of the individual may have changed, as there may have been psychiatry related incidents, a change in medications, and so forth. The presence of the psychiatrist always allows for richer discussion during the ISP with regard to the required elements.

21. In all examples, there was 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: PSP were not current/updated for all individuals. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
22	If the IDT and psychiatrist determine that a Psychiatric Support Plan (PSP) is appropriate for the individual, required documentation is provided.	50% 1/2	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A

Comments:
22. None of the individuals in the review group had a PSP. Therefore, PSP documents regarding Individual #82 and Individual #79 were reviewed. The PSP for Individual #79 was out of date as it was implemented in December 2015. The PSP regarding Individual #82, although relatively brief, contained all the required information.

Outcome 9 – Individuals and/or their legal representative provide proper consent for psychiatric medications.											
Summary: All consent forms were complete for this review and for all individuals for the previous four reviews, too (with some exceptions in April 2017). Therefore, indicator 29 will be moved to the category of requiring less oversight. Indicator 31 also showed improvement. Additional work on risk-benefit components of the consent was needed. Indicators 30 and 31 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
28	There was a signed consent form for each psychiatric medication, and each was dated within prior 12 months.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
29	The written information provided to individual and to the guardian regarding medication side effects was adequate and understandable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
30	A risk versus benefit discussion is in the consent documentation.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1		0/1	0/1
31	Written documentation contains reference to alternate and/or non-pharmacological interventions that were considered.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1		1/1	1/1
32	HRC review was obtained prior to implementation and annually.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

29. The consent forms included adequate medication side effect information in all examples. Medication side effect information was included on the form and medication information sheets were attached to the consent forms.

30. The risk versus benefit discussion was not included in the consent forms in the eight examples. There was information regarding the medication side effects and the risk to the individual with regard to increased symptoms if the medication was not utilized, but the forms did not include a comprehensive risk/benefit discussion.

31. The consent forms in five examples included alternate, individualized, non-pharmacological interventions. The consent forms regarding Individual #69 and Individual #135 contained general recommendations for non-pharmacological interventions as the forms were completed on the day of admission for both of these individuals. The forms noted that additional interventions would be discussed at the upcoming ISP meeting.

In the example regarding Individual #192, the consent forms indicated that non-pharmacological interventions would be determined at the upcoming ISP, but at the time the consents were performed, he had been at the facility for over a year, so the interventions should have been developed.

Psychology/behavioral health

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: All individuals who needed a PBSP had one. Individuals had goals that were relevant and measurable. This has been the case for this and the previous three reviews, with just some exceptions. Therefore, indicators 2 and 3 will be moved to the category of requiring less oversight. Most goals were based on assessments, but not all were at this point. Data were shown to be reliable for more individuals than ever before. This is a requirement for making good treatment decisions, especially given the recent behavioral and psychiatric challenges presented by many individuals. Indicators 1, 4, and 5 will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
1	If the individual exhibits behaviors that constitute a risk to the health or safety of the individual/others, and/or engages in behaviors that impede his or her growth and development, the individual has a PBSP.	100% 10/10	1/1	1/1	1/1	1/1	1/1	1/1	N/A	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% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
3	The psychological/behavioral goals/objectives are measurable.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	N/A	1/1	1/1
4	The goals/objectives were based upon the individual's assessments.	75% 6/8	1/1	1/1	0/1	1/1	1/1	0/1	N/A	1/1	1/1
5	Reliable and valid data are available that report/summarize the individual's status and progress.	88% 7/8	1/1	1/1	1/1	0/1	1/1	1/1	N/A	1/1	1/1

Comments:

1. Of the 16 individuals reviewed by both Monitoring Teams, 10 required a PBSP (eight individuals reviewed by the behavioral health Monitoring Team and two individuals reviewed by the physical health Monitoring Team). All of those individuals had PBSPs.

4. Individual #170 and Individual #187's replacement behaviors in their functional assessments were different from those found in their most recent progress notes (July 2018).

5. Individual #135, Individual #192, Individual #170, Individual #69, Individual #187, Individual #198, and Individual #181 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 #108's most recent IOA measure was below 80%. When IOA or DCT measures fall below the established minimal level, staff should be retrained and another assessment should be conducted with that staff member as soon as possible. This represents an improvement in the reliability of PBSP data from the last review when 57% of individuals had documentation of reliable data.

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

Summary: Criteria for annual behavioral health assessments were met for all individuals for this and the previous three reviews with one exception during this review and the previous review. Therefore, indicator 10 will be moved to the category of requiring less oversight. With sustained high performance, the same might occur for indicator 11 after the next review. Some attention to content of functional assessments is needed to allow indicator 12 to also be moved to this category. Indicators 11 and 12 will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
10	The individual has a current, and complete annual behavioral health update.	88% 7/8	1/1	0/1	1/1	1/1	1/1	1/1	1/1		1/1
11	The functional assessment is current (within the past 12 months).	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A		1/1
12	The functional assessment is complete.	71% 5/7	1/1	1/1	1/1	1/1	1/1	0/1	N/A		0/1

Comments:
Criteria for indicators 1-9 were met for Individual #198. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for him.

10. Individual #192's annual behavioral health update did not have an assessment of intellectual ability.

12. Individual #192, Individual #135, Individual #69, Individual #108, and Individual #170 had complete functional assessments. The Monitoring Team found Individual #170's functional assessments to be particularly clear and through.

Individual #187's functional assessment was rated incomplete because the summary statement was inconsistent with the direct and indirect assessment results, without a rationale for why they were unrelated. Individual #181's functional assessment was rated incomplete because identified antecedent events and consequence were not consistent with direct and indirect assessment results, without a rationale for the discrepancy.

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.												
Summary: All three indicators showed improvement since the last review, and for three individuals, all three indicators were at criteria. PBSPs were current and about half contained all of the required components. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	86% 6/7	1/1	1/1	1/1	0/1	1/1	1/1	N/A		1/1
14	The PBSP was current (within the past 12 months).	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A		1/1
15	The PBSP was complete, meeting all requirements for content and quality.	57% 4/7	0/1	1/1	0/1	1/1	1/1	1/1	N/A		0/1
Comments: 13. There was documentation that PBSPs were implemented within 14 days of attaining all necessary consents/approvals for all individuals other than Individual #108. This represents a dramatic improvement from the last review when 29% of individuals had documentation that PBSPs were implemented within 14 days of attaining all necessary consents/approvals. 15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan. Four of the PBSPs were rated as containing all of these components. Individual #170's PBSP was rated as incomplete because replacement behavior in the PBSP was different from that in the functional assessment. Individual #181 and Individual #135's PBSPs were rated as incomplete because the PBSP appeared to inadvertently reinforce aggressive verbal behavior.											

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.												
Summary: This outcome did not apply to any individuals in the review group. It will remain in active monitoring for possible review at the next onsite visit.			Individuals:									
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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
Comments: 24-25. None of the individuals in the review group were referred or received counseling services. Counseling at El Paso SSLC (for some												

of the other individuals) was provided in the community and, therefore, this indicator was not scored.

Medical

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Based on the Monitoring Team's review of annual medical assessments for review of other indicators, PCPs completed 33% of them late. At the time of the last review, similar issues existed. As a result, Indicator b will move back to active monitoring. Center staff should ensure individuals' ISPs/IHCPs define the frequency of interim medical reviews, based on current standards of practice, and accepted clinical pathways/guidelines. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	For an individual that is newly admitted, the individual receives a medical assessment within 30 days, or sooner if necessary depending on the individual's clinical needs.	Due to the Center's sustained performance, these indicators moved to the category requiring less oversight. However, based on the Monitoring Team's review of annual medical assessments for review of other indicators, PCPs completed 33% of them late. Similar problems were noted at the time of the last review, and the Center apparently did not correct the issue. As a result, Indicator b will move back to active monitoring.									
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 the last report, the Monitoring Team noted that three of the AMAs reviewed were late, and warned the Center that if this issue was not corrected, this indicator might return to active oversight. Unfortunately, based on this review, 33% of the AMAs reviewed were late. As a result, this indicator will 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." Interim reviews need to occur a minimum of every six months, but for many individuals' diagnoses and at-risk conditions, interim 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 quality of plans of care to address active problems. Indicators a and c will remain in active oversight. If PCPs do not update their diagnostic nomenclature, Indicator b is at risk of returning to active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual receives quality AMA.	22% 2/9	0/1	0/1	1/1	0/1	1/1	0/1	0/1	0/1	0/1
b.	Individual's diagnoses are justified by appropriate criteria.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
c.	Individual receives quality periodic medical reviews, based on their individualized needs, but no less than every six months.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments: a. It was positive that two individuals' AMAs (i.e., Individual #32, and Individual #155) included all of the necessary components, and addressed individuals' medical needs with thorough plans of care. Problems varied across the remaining medical assessments the Monitoring Team reviewed. It was positive that as applicable to the individuals reviewed, all annual medical assessments addressed pre-natal histories, social/smoking histories, past medical histories, complete interval histories, allergies or severe side effects of medications, lists of medications with dosages at the time of the AMA, complete physical exams with vital signs, pertinent laboratory information, and updated active problem lists. Most, but not all included, as applicable, family history, and childhood illnesses. Moving forward, the Medical Department should focus on ensuring medical assessments include quality plans of care for each active medical problem, when appropriate.

b. For six out of 18 diagnoses reviewed, PCPs used incorrect diagnostic nomenclature (e.g., "essential hypertension" instead of primary hypertension, "borderline diabetes" instead of pre-diabetes, "abnormal skin test" instead of latent tuberculosis). If these issues are not corrected, after the next review, this indicator might return to active oversight.

c. For nine individuals, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions [Individual #187 – seizures, and constipation/bowel obstruction; Individual #170 – diabetes, and weight; Individual #32 – infections, and diabetes; Individual #118 – other: Vitamin D deficiency, and gastrointestinal (GI) problems; Individual # 155 – constipation/bowel obstruction, and other: breast cancer; Individual #58 – osteoporosis, and other: anemia; Individual #115 – seizures, and infections; Individual #177 – diabetes, and other: chronic back pain; and Individual #107 – cardiac disease, and GI problems].

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

Outcome 9 – Individuals' ISPs clearly and comprehensively set forth medical plans to address their at-risk conditions, and are modified as necessary.											
Summary: As indicated in the last several reports, much improvement was needed with regard to the inclusion of medical plans in individuals' ISPs/IHCPs.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	The individual's ISP/IHCP sufficiently addresses the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations.	17% 3/18	0/2	0/2	0/2	1/2	0/2	1/2	1/2	0/2	0/2
b.	The individual's IHCPs define the frequency of medical review, based on current standards of practice, and accepted clinical pathways/guidelines.	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, the Monitoring Team selected for review a total of 18 of their chronic diagnoses and/or at-risk conditions (i.e., Individual #187 – seizures, and constipation/bowel obstruction; Individual #170 – diabetes, and weight; Individual #32 – infections, and diabetes; Individual #118 – other: Vitamin D deficiency, and GI problems; Individual # 155 – constipation/bowel obstruction, and other: breast cancer; Individual #58 – osteoporosis, and other: anemia; Individual #115 – seizures, and infections; Individual #177 – diabetes, and other: chronic back pain; and Individual #107 – cardiac disease, and GI problems). The following IHCPs included action steps to sufficiently address the chronic or at-risk condition in accordance with applicable medical guidelines, or other current standards of practice consistent with risk-benefit considerations: Individual #118 – GI problems, Individual #58 – osteoporosis, Individual #115 – seizures, and Individual #107 – GI problems. 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 good to see that for the individuals reviewed, the Dental Department completed timely annual dental summaries. If the Center sustains this progress, Indicator a.iii might move to the category requiring less oversight after the next review. The Center should continue its focus on completing timely annual dental exams, as well as improving the quality of dental exams, particularly with regard to treatment plans, as well as summaries.			Individuals:								
#	Indicator	Overall	187	170	32	118	155	58	115	177	107

		Score									
a.	Individual receives timely dental examination and summary:										
	i. For an individual that is newly admitted, the individual receives a dental examination and summary within 30 days.	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.	67% 6/9	1/1	0/1	1/1	0/1	1/1	0/1	1/1	1/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	Individual receives a comprehensive dental examination.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Individual receives a comprehensive dental summary.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1

Comments: b. It was positive that the dental exams reviewed included the following:

- A description of the individual's cooperation;
- An oral hygiene rating completed prior to treatment;
- Periodontal condition/type;
- The recall frequency;
- Caries risk;
- Periodontal risk;
- An oral cancer screening;
- Sedation use;
- A summary of the number of teeth present/missing;
- Information regarding last x-ray(s) and type of x-ray, including the date;
- Treatment provided/completed; and
- An odontogram;

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 treatment plan to address the individual's needs (e.g., individuals with periodontal disease often did not have plans to address their needs); and
- Periodontal charting.

c. It was good to see that all of the dental summaries reviewed included the following:

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

- Dental care recommendations;
- Provision of written oral hygiene instructions; and
- Recommendations for the risk level for the IRRF.

Most, but not all included:

- Treatment plan, including the recall frequency.

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

- 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: For most individuals reviewed, nursing staff had not documented full physical assessments. The remaining indicators require continued focus to ensure 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	Individuals: 187	170	32	118	155	58	115	177	107
a.	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	N/A									
	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.	11% 1/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	1/1	0/1
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	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.	40% 4/10	N/A	1/2	1/1	0/1	1/2	N/A	1/1	0/1	0/2

Comments: a. For most individuals reviewed, nursing staff had not documented full physical assessments. Some of the problems

included missing assessments of reproductive systems without any indication of whether or not the individual refused, follow-up of vital sign values that were high or low, missing Braden Scales/scores, and/or missing fall assessments/scores. In addition, the Center did not consistently submit the expanded view, and, as a result, words were often cut off.

Of note, for three of the individuals reviewed (i.e., Individual #155, Individual #58, and Individual #107), the Center submitted physical assessments that nurses completed using the old paper format. The Braden Scales for these individuals also were in the old paper format. Although the dates on them showed they were completed timely, they did not have date stamps like the assessments completed in the electronic system. The Center provided no explanation for why nurses did not enter these assessments into the electronic health record (i.e., IRIS). In addition, none of these assessments included fall risk assessments/scores.

b. For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #187 – seizures, and choking; Individual #170 – constipation/bowel obstruction, and infections; Individual #32 – GI problems, and cardiac problems; Individual #118 – dental, and constipation/bowel obstruction; Individual #155 – aspiration, and falls; Individual #58 – infections, and GI problems; Individual #115 – respiratory compromise, and circulatory; Individual #177 – weight, and diabetes; and Individual #107 – GI problems, and skin integrity).

Overall, none of the annual comprehensive nursing assessments contained reviews of risk areas that were sufficient to assist the IDTs in developing a plan responsive to the level of risk. Often, nurses did not include complete status updates, including relevant clinical data, and/or nurses had not analyzed this information, including comparisons with the previous quarter or year. Often, nurses did not make relevant 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 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 4/27/18, a nursing IPN entry noted that Individual #170 had not had a bowel movement in 72 hours. The nurse indicated this information would be passed on to the next shift. However, nurses did not conduct any nursing assessment or follow-up until on 4/28/18, at 3:30 p.m., a nurse documented that staff reported the Individual #170 was having a large emesis. The nurse noted the individual had not had a bowel movement in 120 hours (i.e., five days). Based on the individual's presenting signs and symptoms, and the nurse's physical assessment findings, the nurse followed the nursing guidelines, including physician notification, which was good to see. However, as discussed above, as well as elsewhere in this report, nursing staff did not conduct assessments to prevent this emergent situation (i.e., the individual was transferred to the ED with a bowel obstruction).
- On 3/27/18, nursing staff conducted an assessment of Individual #118 for pain and GI issues. The nurse noted active bowel sound in four quadrants. A medical IPN, dated 3/27/18, noted: "referred to clinic nursing concerns she is in pain. Has been refusing meals. No vomiting, no diarrhea. Little stooling." The PCP's assessment was anorexia.

  A medical IPN, dated 3/28/18, noted that the x-ray revealed severe rectal fecal impaction requiring manual removal; oil retention enema if needed after a manual extraction. Nursing IPNs noted this was done.

On 4/1/18 at 2:14 p.m., a nursing IPN documented follow-up on Individual #118's emesis, heart rate of 120, and no bowel movement in 72 hours. This nurse followed nursing guidelines/standards of care, including notification of the PCP for an elevated pulse rate, and no bowel movement. The PCP ordered a stat KUB. A nursing IPN, dated 4/1/18, at 6:50 p.m., noted the nurse reported the results to the PCP. The PCP ordered transport to the ED for impaction and severe ileus. Although the nurse that conducted this final assessment prior to the individual's transfer to the hospital followed applicable nursing guidelines, the documents submitted did not include descriptions of ongoing nursing assessments from the time of the initial assessment, on 3/27/18, to show nursing follow-up on this significant change of status.

- On 4/1/18, at 3:01 a.m., a nursing IPN documented subjective findings that staff were assisting Individual #155 on to her recliner, when she proceeded to side down, but because she was not close enough to the recliner, the individual fell onto the floor on her buttocks. The remainder of the Subjective, Objective, Assessment, Plan (SOAP) note did not make further mention of an assessment. A Post-Injury Report, dated 3/31/18, at 7:00 p.m., noted a fall as described above, and indicated the date and time of the witnessed incident was 3/31/18 at 7:00 p.m. The record was confusing with an RN noting vital signs at 4/3/18 10:09 a.m., and a Licensed Vocational Nurse (LVN) noting a pain assessment on 4/1/18, at 2:53 a.m. In addition, in the Center's response to document request #33 for falls, post-fall evaluation, and IView entries, documentation for the 4/1/18 fall date were not found. Based on the inadequacy of the documentation, the Monitoring Team could not determine compliance with standards of care for falls.
- Based on an IView entry on 2/15/18 at 12:00 p.m., Individual #177 had a blood glucose finger stick reading of 239 (i.e., range 74-106). Based on the out-of-range blood sugar reading, the nurse should have conducted an assessment for signs/symptoms of hyperglycemia, or any complaints from the individual, but no corresponding nursing IPN was found. Moreover, it was perplexing that nurses did not have written parameters (orders) for reporting a high or low blood sugar to the PCP based on findings from the blood glucose testing nurses performed four times each day.
- A nursing IPN, dated 4/7/18, at 6:30 a.m., indicated: "assessed at 0336." The record reported: "[Individual #107] had a large emesis, had encountered [the individual] in his room while he had his hand in his brief and had put some stool in his mouth." Although the initial nursing assessment followed nursing standards of care, including performing gastroccult testing, the nurse did not follow the standards of care for instructing the individual and staff on infection control practices related to the stool ingestion.
- On 4/2/18 at 11:40 a.m., a nurse created a record entitled Nursing Forms Entry for Discovered Incident. The nurse described the incident as staff reporting redness to Individual #107's left foot by his big toe (i.e., bony area). The nurse described the injury as 1 centimeter (cm) times 1 cm redness to the left big toe knuckle. The skin integrity issue was thought to be an issue related to his shoe. The next nursing IPN entry, dated 4/2/18, at 9:11 p.m., related to a nebulizer treatment, and made no mention of the skin integrity issue. The next nursing IPN, dated 4/3/18, at 10:28 a.m., indicated the QDIP and Registered Nurse Case Manager (RNCM) were assessing the redness. In this note, the nurse did not provide a measurement, but did note the individual's shoelaces were very tight, and bending a part of the shoe, which was probably the cause of the friction in that area. An IPN, dated 4/4/18, at 11:13 a.m., indicated that the RNCM notified the PCP of the skin issue. A corresponding medical IPN, dated 4/4/18, at 6:43 p.m., noted the PCP conducted a physical exam, which revealed a 1.5 cm lesion of the dorsum of the left foot over a bony prominence. Nurses did not follow nursing standards of care for the initial skin assessment (i.e., on 4/2/18, at 11:40 a.m.). For example, the Center's skin guidelines state: "when reddened areas are found, the nurse should check for blanching." In addition, the nurse included no documentation in IView for Wound-Skin.

The next IPN that related to his left foot and an identified skin issue was dated 4/9/18, at 3:59 p.m. This medical IPN stated: "Left foot with 8-9mm [millimeter] lesion of mid distal foot, ulceration, continues to be tender." The next nursing IPN related to skin integrity, dated 4/24/18, at 4:38 p.m., related to his left ear redness. In other words, between 4/10/18 an 4/24/18, neither nursing staff nor medical staff conducted assessments of the skin integrity issue on his toe and/or documented assessments in IPNs. As a result, it was not possible to determine whether the skin issue worsened, remained the same, or improved.

The following provide positive examples:

- According to a nursing IPN, dated 2/1/18, at 12:15 p.m., staff notified the nurse at 7:50 a.m., that the Individual #170 had difficulty walking on his left foot. The nurse conducted an assessment of the affected area that was in alignment with nursing guidelines and the individual's signs/symptoms, including physician notification, and measurements of the skin issue.
- On 4/9/18, Individual #32 returned to the Center from the hospital with diagnoses of cellulitis of the left hand, hypernatremia, dehydration, acute kidney injury, and failure to thrive with a PEG placement. A nursing IPN, dated 4/9/18, at 10:26 p.m., and IView entries, dated 4/9/18 at 7:21 p.m., documented a post-hospital initial assessment. According to this documentation, the nurse conducted assessments that followed standards of care based on the individual's signs and symptoms and recent discharge diagnoses, including G-tube placement.
- For Individual #155, in an IPN, dated 3/25/18, at 12:54 p.m., and an addendum IPN, dated 3/25/18, at 5:45 p.m., a nurse documented signs and symptoms of nasal drainage and congestion. The record documented the nurse notified the Registered Nurse (RN) to request further assessment. Based on the RN assessment, the plan was to refer the individual to the clinic. A late entry IPN, dated 3/25/18, at 4:56 p.m., noted that the LVN contacted the RN at 3:55 p.m., and the RN arrived the home at 4:00 p.m. At that time, oxygen was initiated, and staff called Emergency Medical Services (EMS). Individual #155 transferred to the ED for respiratory distress. Based on the individual's signs and symptoms of respiratory distress, the nurse followed applicable standards of care for respiratory distress and nurses were prudent in their actions in calling 911 (i.e., when the nurse could not reach the PCP).
- In an IPN, dated 8/14/18, at 5:00 a.m., a nurse documented responding to a direct support professional who asked the nurse to assess Individual 115: "he feels warm." The nurse documented a respiratory assessment, and vital signs. The individual's respiratory rate was 18, and described as shallow. The IPN indicated the nurse would refer him to the clinic. A nursing IPN, dated 8/14/18, at 6:20 a.m., included vital signs, and results of a respiratory assessment, noting a shallow respiratory pattern. A nursing IPN, dated 8/14/18, at 9:20 a.m., and IView documentation and nursing IPN, dated 8/13/18, at 9:20 a.m., documented vital signs and respiratory assessments. At 8:45 a.m., the individual went to the clinic for evaluation. A medical IPN, dated 8/14/18, at 10:04 a.m., noted a PCP assessed him, and ordered a DuoNeb updraft treatment. The individual was transferred to the ED for further evaluation due to worsening of his respiratory status and severe weakness. Subsequently, he was admitted to the hospital. Based on the initial signs and symptoms the individual exhibited on 8/14/18, nursing staff followed standards of care for assessment.

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 several 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	187	170	32	118	155	58	115	177	107
a.	The individual has an ISP/IHCP that sufficiently addresses the health risks and needs in accordance with applicable DADS SSLC nursing protocols or current standards of practice.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
b.	The individual's nursing interventions in the ISP/IHCP include preventative interventions to minimize the chronic/at-risk condition.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
c.	The individual's ISP/IHCP incorporates measurable objectives to address the chronic/at-risk condition to allow the team to track progress in achieving the plan's goals (i.e., determine whether the plan is working).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
d.	The IHCP action steps support the goal/objective.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
Comments: a. through f. Overall, the ISPs reviewed did not clearly and comprehensively set forth nursing plans to address their existing conditions, including at-risk conditions.											

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: Since the last review, the scores during this review generally showed improvement with regard to timely referral of individuals to the PNMT, and timely completion of the PNMT initial review. The Center should focus on sustaining its progress in these areas, completion of PNMT comprehensive assessments for individuals needing them, involvement of the necessary disciplines in the review/assessment, and the quality of the PNMT comprehensive assessments.	Individuals:

These indicators will remain in active oversight.											
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	83% 5/6	N/A	1/1	1/1	0/1	1/1	N/A	1/1	N/A	1/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	83% 5/6		1/1	1/1	0/1	1/1		1/1		1/1
c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	40% 2/5		0/1	N/A	0/1	1/1		1/1		0/1
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	50% 3/6		0/1	1/1	0/1	1/1		1/1		0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	33% 2/6		0/1	1/1	1/1	0/1		0/1		0/1
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	17% 1/6		0/1	1/1	0/1	0/1		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.	33% 1/3		0/1	0/1	N/A	N/A		1/1		N/A
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5		0/1	N/A	0/1	0/1		0/1		0/1

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

- On 5/2/18, the PNMT completed a review related to Individual #170's hospitalization, from 4/28/18 to 4/29/18, with a discharge diagnosis of bowel obstruction. Given his previous history of constipation, bowel obstruction, and emesis in 2017, the PNMT should have completed a comprehensive assessment rather than just a review.

  The review the PNMT completed did not address aspiration risk related to his emesis. The review included no discussion of related medical history prior to 2016 (colonoscopy). The PNMT offered no overview or discussion of his extensive vomiting for the last year (on 5/4/17, the PNMT completed a previous evaluation with ongoing follow-up by PNMT related to this issue

through 12/18/17 with recommendations at that time).

- Individual #32 had been on the PNMT caseload previously due to weight loss, gastrostomy tube (G-tube) placement and eventual removal on 2/16/18. The PNMT was following him for weight at least through 6/6/18. However, on 4/4/18, he was hospitalized for partial amputation of his left fourth distal phalanx with G-tube placement, and on 4/9/18, he was discharged from the hospital. On 4/11/18, the PNMT completed a review. The PNMT review did not identify the need to update his IHCP and outcomes related to this significant change of status.
- For Individual #118, no evidence was found of a PNMT review or assessment after weight loss of 11.57% in four months (she weighed 67.40 pounds on 6/5/17, and 59.6 pounds on 10/10/17). Subsequent continued weight loss, resulted in PNMT discussion on 12/13/17. The PNMT reported that she was back up to her "normal" weight, though at 62.20 pounds on 12/11/17, she remained well below her average weight of 66.05 in June 2017. Since 10/10/17, with the low weight of 59.60, her average weight after that time through 12/11/17, was only 60.86 pounds, which was nearly 8% below the previous June average. On 2/20/18, her weight loss continued to a low of 57.60. The PNMT did not conduct a comprehensive assessment, but rather only a review on 2/28/18, despite weight loss contributing to a pressure ulcer on her right hip, noted on 2/26/18.
- For Individual #155, the timeline of events was confusing. In the heading of the comprehensive assessment and on the list the Center submitted as part of the Tier 1 document request, 3/7/18 was listed as the referral date. However, the PNMT described the qualifying event as aspiration pneumonia with hospitalization from 3/25/18 to 3/31/18 (i.e., which was after the reported date of referral). The body of the report stated referral occurred on 4/2/18. A review was completed on 4/4/18, with a recommendation for a comprehensive assessment, which the PNMT completed on 5/2/18. Despite an apparent error, the Monitoring Team gave the PNMT the benefit-of-the-doubt, and made the assumption the actual referral date was 4/2/18, after the qualifying event.
- Individual #115 experienced seven to eight episodes of emesis over a two-day period (1/12/18 to 1/13/18), and also met re-referral criteria the PNMT established in 2016 (i.e., greater than 5% weight loss in a given month, 10 or more aspiration triggers during mealtimes in a given month, and three or more nocturnal emesis in a given week). On 1/17/18, the IDT made a referral, and on 2/14/18, the PNMT completed an assessment. He also had a recent diagnosis of aspiration pneumonia from 12/27/17 to 12/31/17 (PNMT documented that imaging did not clinically support that diagnosis and no evaluation was completed at that time). He had subsequent episodes of aspiration pneumonia documented on 5/30/18 (hospitalized 5/30/18 to 6/4/18 and a self-referral was made on 6/6/18 with an evaluation completed on 6/27/18), and 8/14/18 (no evaluation submitted). A PNMT review, dated 8/22/18, was completed for the August episode (8/14/18 to 8/17/18). No nurse participated in either assessment submitted, and only the PT signed the assessment, dated 6/27/18. A nurse and other core team members listed as "signed by" for the review.

  In its comments on the draft report, the State disputed the Monitoring Team's findings related to the participation of PNMT members in the assessment process. The State indicated: "…the signature sheet was also attached in TX-EP-1810.II.72 page 161 of 171, to reflect that other team members were also part of the discussion and the meeting…. Additionally, this PNMT Review (8/22/18) was signed by the PNMT RN as noted in the header in TX-EP-1810.II.72 page 147 of 171." However, in its production of documents, the Center did not submit a response to Document Request #72 (i.e., or Document Request #71 or 73). The Lead Monitor double checked the files in SharePoint, and this file did not exist.
- From 12/30/17 to 1/2/18, Individual #107 was admitted to the hospital for gastritis and/or small bowel obstruction. He had a number of previous hospitalizations. On 1/3/18, the PNMT completed a review in which they reported he had both gastritis

and a small bowel obstruction. The PNMT merely stated that based on review of data and supports an assessment was not indicated. They provided no specific clinical justification for this decision.

e. Often, an RN Post-Hospitalization Review was completed for the individuals reviewed, but the PNMT did not discuss and/or document discussion of the results. At times, though, no RN review was completed, due to a lack of a PNMT RN.

h. As noted above, three individuals who should have had comprehensive PNMT assessments did not (i.e., Individual #170, Individual #118, and Individual #107). The following summarizes some of the concerns noted with the two assessments that the PNMT completed:

- For Individual #155, the PNMT did not discuss data to determine whether or not the current risk ratings were correct, but merely listed outcomes and action steps from the IHCPs. Behavior was listed as a medium risk, but the assessment only reported that the IDT had not developed an IHCP goal or actions for this risk area, and the PNMT did not make recommendations related to this issue. The PNMT did not discuss whether or not existing supports were effective, and provided no results of monitoring in the months prior to the qualifying event. The assessment indicated that PNMT management was not needed, but outlined no rationale, no goals, and no clinical indicators or thresholds.
- For Individual #115, the PNMT did not discuss data to determine whether or not the current risk ratings were correct, but merely listed outcomes and action steps from the IHCPs. The PNMT recommended some "goals," but they were not all measurable and not clearly related to the analysis offered.

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

Summary: Overall, ISPs/IHCPs did not comprehensively set forth plans to address individuals' PNM needs. In some cases, IDTs had included many necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps. In addition, many action steps were not measurable. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
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).	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 plan includes preventative interventions to minimize the condition of risk.	28% 5/18	0/2	0/2	1/2	1/2	1/2	1/2	0/2	0/2	1/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	0% 0/8	0/1	0/1	0/1	0/1	0/1	0/1	0/1	N/A	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	2/2	0/2	0/2	0/2	0/2	0/2	0/2
e.	The individual's ISP/IHCP identifies the clinical indicators necessary to measure if the goals/objectives are being met.	6% 1/18	0/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	6% 1/18	0/2	0/2	0/2	0/2	1/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	28% 5/18	2/2	0/2	1/2	1/2	1/2	0/2	0/2	0/2	0/2

Comments: The Monitoring Team reviewed 18 IHCPs related to PNM issues that nine individuals' IDTs and/or the PNMT working with IDTs were responsible for developing. These included IHCPs related to: Individual #187 - falls, and choking; Individual #170 – aspiration, and constipation/bowel obstruction; Individual #32 – falls, and weight; Individual #118 – fractures, and weight; Individual #155 - falls, and aspiration; Individual #58 – falls, and aspiration; Individual #115 – falls, and aspiration; Individual #177 – weight, and falls; and Individual #107 – fractures, and constipation/bowel obstruction.

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. In some cases, IDTs had included many necessary PNM interventions in individuals' ISPs/IHCPs, which was movement in the right direction. However, the plans were still missing key PNM supports, and often, the IDTs had not addressed the underlying cause or etiology of the PNM issue in the action steps (e.g., if behavior was a frequent cause of falls, measurable interventions to address the behaviors should be included; or if an individual was at increased risk of choking due to a fast eating pace or improper positioning during meals, then measurable action steps are needed to address these factors). In addition, many action steps were not measurable (e.g., "encourage upright positioning during and after medication pass," "encourage walking," etc.).

The IHCPs that included the necessary preventative measures were for: Individual #32 – falls, Individual #118 – fractures, Individual #155 - falls, Individual #58 – falls, and Individual #107 – fractures.

c. Eight of the individuals reviewed had PNMPs and/or Dining Plans.

- None of the PNMPs reviewed included the risk levels for the risk areas identified.
- Within the last 12 months, IDT had reviewed and/or updated all eight PNMPs.
- It was positive that all of the PNMPs, as applicable to the individuals' needs included:
  - Triggers (i.e., signs and symptoms);
  - Photographs;
  - Descriptions of assistive/adaptive equipment;
  - Positioning instructions;
  - Transfer instructions;
  - Mobility instructions;
  - Handling precautions or moving instructions; and
  - Oral hygiene instructions.

- Most, but not all PNMPs reviewed included the necessary:
  - Bathing instructions;
  - Toileting/personal care instructions;
  - Mealtime instructions;
  - Medication administration instructions; and
  - Complete communication strategies.

With minimal effort and attention to detail, the Habilitation Therapy staff could make the needed corrections to PNMPs, and by the time of the next review, the Center could make good progress on improving individuals' PNMPs.

d. The IHCPs that included the steps necessary to meet the measurable goals/objectives were for: Individual #32 – falls, and weight.

e. The IHCP that identified the necessary clinical indicators was for: Individual #32 – weight.

f. The IHCP that identified triggers and actions to take should they occur was for: Individual #155 - aspiration.

g. Often, the IHCPs reviewed did not include PNMP monitoring, or did not define the frequency of PNMP monitoring. Those that did were for: Individual #187 - falls, and choking; Individual #32 – weight; Individual #118 – weight; and Individual #155 - falls.

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	187	170	32	118	155	58	115	177	107
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.	67% 2/3	N/A	N/A	0/1	N/A	1/1	N/A	1/1	N/A	N/A
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/3			0/1		0/1		0/1		

Comments: a. and b. For Individual #32, the IDT did not modify his IRRF/IHCP to address the various changes with his G-tube use. They did not develop a plan with a well-outlined rationale and action steps to address his safe movement along the continuum to oral intake.

Individual #155's IRRF discussed the IDT's efforts to try extra- and intra-oral stimulation, and provided a rationale for continued tube use. The IDT indicated that efforts for oral motor intervention would occur the next quarter. However, the IDT did not describe a plan,

or establish goals or timelines. On 8/1/18, according to an IPN, the SLP initiated direct therapy. The stated goal was to tolerate extra-oral stimulation through passive facial massage and use of vibrachew to the face for five minutes two to three times per week. It appeared, though, that the goal was also her baseline. The SLP provided no evidence of a new assessment to provide the rationale for the intervention.

Individual #115's IDT stated that his primary means of intake was oral at the time of IRRF. Since that time, this had changed, but the Center provided no evidence that the IDT revised the IRRF, even though he had aspiration episodes and returned to primary use of the G-tube for intake. This change had been in place at least since 6/6/18, when his PNMP identified that he was nothing-by-mouth (NPO) status.

Occupational and Physical Therapy (OT/PT)

Outcome 2 – Individuals receive timely and quality OT/PT screening and/or assessments.											
Summary: The Center's performance with regard to the timeliness of OT/PT assessments, as well as the provision of OT/PT assessments in accordance with the individuals' needs has varied. Although some improvement was noted, the quality of OT/PT assessments continues to be an area on which Center staff should focus. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual receives timely screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely OT/PT screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's comprehensive OT/PT assessment is completed within 30 days.	N/A									
	iii. Individual receives assessments in time for the annual ISP, or when based on change of healthcare status, as appropriate, an assessment is completed in accordance with the individual's needs.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
b.	Individual receives the type of assessment in accordance with her/his individual OT/PT-related needs.	78% 7/9	1/1	0/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual receives quality screening, including the following: • Level of independence, need for prompts and/or	0% 0/1	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	supervision related to mobility, transitions, functional hand skills, self-care/activities of daily living (ADL) skills, oral motor, and eating skills; • Functional aspects of: ▪ Vision, hearing, and other sensory input; ▪ Posture; ▪ Strength; ▪ Range of movement; ▪ Assistive/adaptive equipment and supports; • Medication history, risks, and medications known to have an impact on motor skills, balance, and gait; • Participation in ADLs, if known; and • Recommendations, including need for formal comprehensive assessment.										
d.	Individual receives quality Comprehensive Assessment.	29% 2/7	N/A	0/1	N/A	1/1	1/1	0/1	0/1	0/1	0/1
e.	Individual receives quality OT/PT Assessment of Current Status/Evaluation Update.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

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

- For Individual #170, the OT/PT completed an assessment, dated 5/21/18, for ISP held on 6/5/18. It stated that the PNMT indicated that he should have a PNMP re-instated on 5/15/17, but the 2018 OT/PT update did not include a discussion or rationale as to why the PNMP was re-instated.
- For Individual #177, although some IPNs and a consult were submitted, the Center did not submit evidence of an assessment or screening, despite his use of adaptive equipment, the possible need for a home exercise program, and at least one fall. His previous comprehensive assessment was completed in 2014, and the evaluators did not provide sufficient clinical justification for not completing another one at the three-year mark.
- Of note, five individuals had comprehensive assessments completed recently. However, OTs/PTs had completed their previous comprehensive assessments from between 2012 and 2014. Evaluators had not previously sufficiently justified the rationale for exceeding the three-year requirement for comprehensive reassessment. Although it was positive that for this review, comprehensive assessments had been completed, Center staff are cautioned that moving forward comprehensive assessments should be completed no later than the three-year mark, unless evaluators provide clear clinical justification for not doing so.

c. Individual #187's screening did not address medications, or risks and their impact on her motor skills, etc. The evaluators identified that a 3-in-1 chair for bathing was not appropriate in her new home, yet offered no recommendation about what to do about this. Instead it indicated the OT/PT would pad the safety belt for the 3-in-1 to prevent skin issues on her hip when she leaned forward.

d. It was positive that the assessments for Individual #118 and Individual #155 met criteria for a quality assessment. As noted above,

the Center did not submit assessments for Individual #170 and Individual #177. It was positive that all of the remaining three comprehensive assessments reviewed met criteria, as applicable, with regard to:

- The individual's preferences and strengths were used in the development of OT/PT supports and services;
- Discussion of pertinent health risks and their associated level of severity in relation to OT/PT supports;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to OT/PT supports and services;
- Functional description of fine, gross, sensory, and oral motor skills, and activities of daily living;
- If the individual requires a wheelchair, assistive/adaptive equipment, or other positioning supports, a description of the current seating system or assistive/adaptive equipment, the working condition, and a rationale for each adaptation (standard components do not require a rationale;
- A comparative analysis of current function (e.g., health status, fine, gross, and oral motor skills, sensory, and activities of daily living skills) with previous assessments; and
- Discussion of the effectiveness of current supports (i.e., direct, indirect, wheelchairs, assistive/adaptive equipment, and positioning supports), including monitoring findings.

The Center should focus most on the following sub-indicators:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on OT/PT needs;
- Clear clinical justification as to whether or not the individual would benefit from OT/PT supports and services; and
- As appropriate to the individual's needs, inclusion of recommendations related to the need for direct therapy, proposed SAPs, revisions to the PNMP or other plans of care, and methods to informally improve identified areas of need.

e. It was positive that the two updates reviewed met criteria, as applicable, with regard to:

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

The Center should focus most on the following sub-indicators:

- Clear clinical justification as to whether or not the individual is benefitting from OT/PT supports and services, and/or requires

fewer or more services; and

- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized throughout the day (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

Outcome 3 – Individuals for whom OT/PT supports and services are indicated have ISPs that describe the individual's OT/PT-related strengths and needs, and the ISPs include plans or strategies to meet their needs.

Summary: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and OTs/PTs should work together to make sure IDTs discuss and include information related to individuals' OT/PT supports in ISPs and ISPAs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	50% 4/8	1/1	1/1	N/A	0/1	1/1	0/1	0/1	0/1	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% 0/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	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% 2/6	0/1	N/A	N/A	1/1	N/A	0/1	0/1	0/1	1/1
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.	67% 2/3	N/A	N/A	N/A	N/A	N/A	0/1	1/1	1/1	N/A

Comments: a. At times, ISPs included recommendations or narrative from assessments that did not provide a functional description of the individuals' OT/PT strengths and needs. Therapists should work with QIDPs to make improvements.

b. Therapists should work with QIDPs to make improvements to address problems such as:

- Simply including a stock statement such as "Team reviewed and approved the PNMP/Dining Plan" did not provide evidence of what the IDT reviewed, revised, and/or approved.
- Individual #118's ISP indicated that an intervention would be added to her PNMP that was not addressed in the assessment (i.e., pillow between legs for bed positioning). In addition, it did not discuss a number of strategies that the assessment recommended, or provide justification for not adding them.

c. and d. Examples of findings included:

- It did not appear that Individual #58's IDT met to discuss changes to her direct OT goal/objective.

• On a positive note, Individual #155 and Individual #177's IDTs met when OT/PT goals needed discussion and approval.

Communication

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: Since the last review, it appeared the Center took steps to address the concerns previously identified in relation to providing individuals with comprehensive assessments at least every three years, unless clear clinical justification is provided for not doing so. The Center is encouraged to continue working to correct these issues. Significant work is needed to improve the quality of communication assessments and updates in order to ensure that SLPs provide IDTs with clear understandings of individuals' functional communication status; AAC options are fully explored; IDTs have a full set of recommendations with which to develop plans, as appropriate, to expand and/or improve individuals' communication skills that incorporate their strengths and preferences; and the effectiveness of supports are objectively evaluated. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual receives timely communication screening and/or assessment:										
	i. For an individual that is newly admitted, the individual receives a timely communication screening or comprehensive assessment.	N/A									
	ii. For an individual that is newly admitted and screening results show the need for an assessment, the individual's communication assessment is completed within 30 days of admission.	N/A									
	iii. Individual receives assessments for the annual ISP at least 10 days prior to the ISP meeting, or based on change of status with regard to communication.	75% 6/8	1/1	1/1	N/A	1/1	1/1	1/1	1/1	0/1	0/1
b.	Individual receives assessment in accordance with their individualized needs related to communication.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1
c.	Individual receives quality screening. Individual's screening	N/A									

	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.										
d.	Individual receives quality Comprehensive Assessment.	0% 0/7	N/A	0/1	N/A	0/1	0/1	0/1	0/1	0/1	0/1
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	0% 0/2	0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. and b. The following provides information about problems noted:

- Center staff did not submit a communication assessment for Individual #177.
- On 5/21/18, Individual #107's assessment was completed for an ISP, dated 2/22/18. The SLP provided no rationale for the assessment not being available for the ISP meeting.
- Of note, five individuals had comprehensive assessments completed recently. However, SLPs had completed their previous comprehensive assessments from between 2012 and 2014. Evaluators had not previously sufficiently justified the rationale for exceeding the three-year requirement for comprehensive reassessment. Although it was positive that for this review, comprehensive assessments had been completed, Center staff are cautioned that moving forward comprehensive assessments should be completed no later than the three-year mark, unless evaluators provide clear clinical justification for not doing so.

d. As noted above, the Center did not submit an assessment for Individual #177. It was positive that, as applicable, all six comprehensive assessments reviewed met criteria with regard to:

- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services; and
- A comparative analysis of current communication function with previous assessments.

Most, but not all met criteria, as applicable, with regard to:

- Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on communication; and
- A functional description of expressive (i.e., verbal and nonverbal) and receptive skills, including discussion of the expansion or

development of the individual's current communication abilities/skills.

The Center should focus most on the following sub-indicators:

- The individual's preferences and strengths are used in the development of communication supports and services;
- The effectiveness of current supports, including monitoring findings;
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether or not the individual would benefit from communication supports and services;
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

e. It was positive that the two updates reviewed met criteria, as applicable, with regard to:

- Discussion of changes within the last year, which might include pertinent diagnoses, medical history, and current health status, including relevance of impact on communication.

The Center should focus most on the following sub-indicators:

- The individual's preferences and strengths are used in the development of communication supports and services;
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services;
- 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;
- The effectiveness of current supports, including monitoring findings;
- 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; and
- As appropriate, recommendations regarding the manner in which strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) should be utilized in relevant contexts and settings, and at relevant times (i.e., formal and informal teaching opportunities) to ensure consistency of implementation among various IDT members.

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

Summary: Improvement is needed with regard to all of these indicators. To move forward, QIDPs and SLPs should work together to make sure IDTs discuss and include information related to individuals' communication supports in ISPs. These indicators will continue in active oversight.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
a.	The individual's ISP includes a description of how the individual	13%	0/1	0/1	N/A	1/1	0/1	0/1	0/1	0/1	0/1

	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.	1/8									
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	14% 1/7	0/1	0/1	N/A	0/1	0/1	0/1	0/1	N/A	1/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g. skill acquisition programs) recommended in the assessment.	42% 5/12	2/3	0/2	0/1	1/1	1/1	0/1	1/1	0/1	0/1
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments: a. Most of the ISPs reviewed were missing important information about the individuals' communication skills and needs (e.g., descriptions of sign language abilities, AAC devices, and/or how others should communicate with the individual).

b. Simply including a stock statement such as "Team reviewed and approved the Communication Dictionary" did not provide evidence of what the IDT reviewed, revised, and/or approved, and/or whether the current Communication Dictionary was effective at bridging the communication gap. In addition, at times, SLPs had identified the need for changes in the assessment, but the ISP did not reflect this need.

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: As anticipated since the last review, performance in SAPs improved since the last review. More were measurable, based on assessments, and meaningful. One-quarter had reliable data. More work is needed, but it was good to see progress occurring. One individual did not have any SAPs and many of the other individuals had only a few, even though they had many skill development needs and would have benefited from additional SAPs. This set of indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
1	The individual has skill acquisition plans.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1

2	The SAPs are measurable.	90% 18/20	2/3	2/2	2/2	2/3	2/2	3/3	None	3/3	2/2
3	The individual's SAPs were based on assessment results.	55% 11/20	2/3	1/2	2/2	3/3	0/2	3/3	None	0/3	0/2
4	SAPs are practical, functional, and meaningful.	30% 6/20	0/3	0/2	1/2	3/3	1/2	1/3	None	0/3	0/2
5	Reliable and valid data are available that report/summarize the individual's status and progress.	25% 5/20	1/3	2/2	0/2	0/3	0/2	1/3	None	0/3	1/2

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 #134, and two SAPs available for Individual #181, Individual #69, Individual #170, and Individual #192 for a total of 20 SAPs for this review.

2. The majority of SAPs were measurable (e.g., Individual #69's identify his staff SAP). Individual #108's turn on the radio SAP did not indicate the objective's prompt level, and Individual #135's call his parents SAP's objective was not clearly written and, therefore, judged as un-measurable.

3. Nine SAPS had no evidence that they were based on assessments results (e.g., Individual #198 inserting his hearing aid SAP).

4. About one-third of the SAPs were judged to be practical and functional (e.g., Individual #170's play his game 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 #181's take his sheets out of the dryer SAP). Other SAPs were not related to the individual's ISP vision statement (e.g., Individual #192's identify pictures of months SAP) and, therefore, were scored as 0 for this indicator.

5. Five SAPs (e.g., Individual #187's press the call button SAP) had interobserver agreement (IOA) demonstrating that the data were reliable. Individual #135's clean his shaver and call his parents SAPs and Individual #108's turn on the radio SAP had integrity data, however, the IOA component was below 80% and, therefore, were scored as 0 for this indicator.

When integrity and/or reliability measures fall below the established criterion, the staff should be retrained and another integrity/reliability measure conducted as soon as possible. Although there is much room for improvement, it is encouraging to see that the Behavioral health department has initiated integrity and reliability assessments for SAPs.

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: All individuals had FSAs. Thus, indicator 10 will be returned to the category of requiring less oversight. Improvement was seen in the other two indicators. These two indicators, 11 and 12, will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
10	The individual has a current FSA, PSI, and vocational assessment.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
11	The individual's FSA, PSI, and vocational assessments were available to the IDT at least 10 days prior to the ISP.	44% 4/9	0/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1
12	These assessments included recommendations for skill acquisition.	67% 6/9	1/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	0/1

Comments:

10. All individuals had current FSAs, PSIs, and vocational assessments. This represented another improvement from the last review when no individuals had current FSAs.

11. Individual #134, Individual #181, Individual #69, Individual #108, and Individual #135's FSAs were not available to the IDT at least 10 days prior to the ISP.

12. Individual #134, Individual #69, and Individual #181's vocational assessments did not include recommendations for SAPs, or a rationale for why a SAP recommendation was not made.

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, 24 of these indicators were moved to, or were already in, the category of requiring less oversight. For this review, six additional indicators were added to this category, in psychiatry, behavioral health, and pharmacy. On the other hand, two indicators were returned to active monitoring, in medical and dental.

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

Goals/Objectives and Review of Progress

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 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.

In psychiatry, quarterly reviews were occurring timely as required and quarterly review documentation contained the required content. For assessment of possible psychotropic medication side effects, there were delays in both the completion of the assessments and the prescriber review of the assessments.

Acute Illnesses/Occurrences

Regarding occurrences of more than three crisis intervention restraints in any rolling 30-day period, progress was seen in the IDT thoroughness of review of variables surround those occurrences.

In psychiatry, emergency clinics were not currently available for individuals because there was no onsite provider available to see individuals. However, the State Office psychiatrist discipline coordinator travelled to the Center and provided psychiatric treatment, including clinical encounters that were scheduled for the week of the monitoring visit.

Regarding psychiatry liaison, one individual was hospitalized at a local psychiatric facility, with plans discussed to send a second individual. Based on discussions, it appeared that the hospital was making medication adjustments in the absence of consultation and/or information from the Center's psychiatry staff. A psychiatry liaison with the inpatient provider should be considered.

With regard to acute illnesses/occurrences, in the months prior to the review, State Office provided training to all of the Centers on the development of acute nursing care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the El Paso SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. Center staff should continue to work with State Office to correct the issues with this critical nursing function.

Significant problems continued to exist 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, for the individuals reviewed, although IDTs often held post-hospital ISPA meetings, the PCPs did not always attend, and ISPAs did not fully address follow-up medical and healthcare supports to reduce risks and promote early recognition.

Based on the one dental emergency reviewed, the dentist provided the individual with timely dental assessment and care. Pain assessment and management, and the completion of related documentation are areas on which the Center should focus.

Implementation of Plans

In psychiatry, there was good collaboration between psychiatry and behavioral health services. That is, the psychiatric documentation referenced the behavioral health target behaviors, and there was documentation of psychiatric participation for individuals with a PBSP. Regarding polypharmacy, psychiatric documentation revealed well-written justifications for polypharmacy. This Center has a history of a comprehensive polypharmacy review committee.

In behavioral health, many individuals had good goals and reliable data. As such, an assessment of progress was able to be made. One individual was determined to be making progress. This was good to see. For the other individuals, either progress was not occurring or there were insufficient/unreliable data. For some individuals who were not progressing, actions were taken and implemented; for others, this was not the case.

Monthly progress notes were now consistently completed and available. An area of focus for El Paso SSLC is to ensure that all staff are trained in PBSPs.

It was good to see that peer review meetings were regularly occurring. Data were presented at clinical meetings and peer review meetings. Follow-up occurred after peer review meetings.

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.

For most individuals' chronic or at-risk conditions reviewed, PCPs working with IDTs had not conducted medical assessment, tests, and evaluations consistent with current standards of care, and/or had not identified the necessary treatment(s), interventions, and strategies, as appropriate. Moreover, IHCPs did not include a full set of action steps to address individuals' medical needs. Although documentation generally was found to show implementation of those action steps assigned to the PCPs that IDTs had included in IHCPs, until IHCPs include a full set of action steps related to medical interventions, this is not a true measure of the Medical Department's success (i.e., a false positive).

Since Round 12, four of the five indicators related to PCPs' review of non-facility consultations moved to the less oversight category. However, based on review of consultations for the remaining indicator, the Monitoring Team noted significant regression with regard to PCPs' timely review of consultations. Often, these reviews were weeks late, and, at times, months overdue. As a result, the related indicator will move back to active monitoring.

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

Seven of eight individuals reviewed (i.e., one individual was edentulous) had not had needed dental treatment. This has been a consistent concern at El Paso SSLC, and needs to be corrected.

Based on the individuals reviewed, practitioners generally implemented recommendations included in Quarterly Drug Regimen Reviews (QDRRs). As a result, one indicator will move to the category requiring less oversight.

It was positive that most individuals observed had equipment that fit them properly.

Based on observations, individuals generally were positioned correctly, and staff completed transfers correctly. However, numerous issues were noted with staff's implementation of Dining Plans. More specifically, errors with Dining Plan implementation were noted in 48% of the 29 mealtime observations. Many of the errors noted placed individuals at risk of choking or aspiration. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies as well as Residential and Day Program/Vocational staff should determine the issues preventing staff from implementing PNMPs, particularly Dining Plans, correctly (e.g., competence, accountability, etc.), and address them.

Restraints

Outcome 7- Individuals who are placed in restraints more than three times in any rolling 30-day period receive a thorough review of their programming, treatment, supports, and services.	
Summary: El Paso SSLC continued to make progress and with sustained high	Individuals:

performance, a number of these indicators might be moved to the category of requiring less oversight after then next review. It was good to see that the Center met criteria for indicators 20, 21, and 22. Indicator 24 will remain in less oversight; the other indicators will remain in active monitoring.											
#	Indicator	Overall Score	192								
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% 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% 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.	100% 1/1	1/1								
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.	100% 1/1	1/1								
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?	100% 1/1	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.	0% 0/1	0/1								
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
25	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a Crisis Intervention Plan (CIP).	0% 0/1	0/1								

26	The PBSP was complete.	N/A	N/A								
27	The crisis intervention plan was complete.	N/A	N/A								
28	The individual who was placed in crisis intervention restraint more than three times in any rolling 30-day period had recent integrity data demonstrating that his/her PBSP was implemented with at least 80% treatment integrity.	100% 1/1	1/1								
29	If the individual was placed in crisis intervention restraint more than three times in any rolling 30-day period, there was evidence that the IDT reviewed, and revised when necessary, his/her PBSP.	100% 1/1	1/1								

Comments:
18-29. This outcome and its indicators applied to Individual #192.

18. Individual #192 had six restraints on 4/3/18, and his ISPA met on 4/4/18 to address more than three restraints in 30 days.

20. Individual #192's 4/4/18 ISPA meeting discussed the potential role of adaptive skills, and biological, medical, and psychosocial issues, and determined that they did not contribute to his restraints on 4/3/18.

21. The IDT determined that setting events did not contribute to Individual #192's restraints.

22. The IDT hypothesized that the antecedent to Individual #192's restraints was not allowing him to eat at another residence. In order to reduce the likelihood of this antecedent resulting in future restraints, the team suggested that if Individual #192 does not want to eat at his residence that he be offered the choice to eat outside.

23. The role of variables maintaining dangerous behaviors provoking restraint was not addressed in Individual #192's 4/4/18 ISPA.

25. Individual #192 did not have a CIP.

Psychiatry

Outcome 1- Individuals who need psychiatric services are receiving psychiatric services; Reiss screens are completed, when needed.											
Summary: None of the individuals in the review groups who were not already receiving psychiatric services had a change of status warranting re-admission. Given the long-standing correct implementation of Reiss scales, the Monitor will move indicators 2 and 3 into the category of requiring less oversight, too.			Individuals:								
#	Indicator	Overall Score									
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									
3	If Reiss indicated referral to psychiatry was warranted, the referral occurred and CPE was completed within 30 days of referral.	N/A									

Comments:
1. Of the 16 individuals reviewed by both Monitoring Teams, six individuals were not receiving psychiatric services. These six individuals, Individual #134, Individual #118, Individual #155, Individual #58, Individual #107, and Individual #115, were screened utilizing the Reiss screen and no additional evaluations were necessary.

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

Summary: For the psychiatric indicators for reduction, progress was seen for two individuals. For psychiatric indicators for increase, problems with the indicators (see monitoring indicator 4) led to zero scores for those. When individuals were showing psychiatric problems, they received IDT and psychiatry attention. These four indicators will remain in active monitoring.

			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
8	The individual is making progress and/or maintaining stability.	0% 0/8	1/2	0/2	0/2	0/2	0/2	0/2		1/2	0/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A		1/1	1/1
11	Activity and/or revisions to treatment were implemented.	100% 6/6	1/1	1/1	1/1	1/1	N/A	N/A		1/1	1/1

Comments:
8. There were examples of individuals who had goals for reduction included in the psychiatric documents, had reliable data, and per the clinical documentation, were making progress with regard to their goals (even though these were not included in the IHCP). Thus, two individuals were scored 1 of 2 in the above scoring table.

- For example, Individual #135 had notations that stability was maintained. He met the psychiatric indicator reduction goals with the exception of his exhibiting four incidents of physical aggression in May 2018 when the goal was for him to exhibit three or less incidents. Other than that, his data for reduction were stable and he was documented to be stable. Even so, Individual #135 continued to require medication adjustments that were documented as addressing anxiety. As such, anxiety may have been a more relevant indicator for reduction.
- In another example, Individual #198 was noted to be stable from a psychiatric perspective and was meeting his goal for

reduction of psychiatric indicators.

- The other individuals in the review group either had unreliable data, such as Individual #108, or were not meeting goals for reduction.

9. No individuals had yet met their psychiatry goals.

10-11. It was apparent that in general, when individuals were deteriorating and experiencing increases in their psychiatric symptoms, changes to the treatment plan (e.g., medication adjustments and alterations to non-pharmacological interventions) were developed and implemented. There was one individual, Individual #187, who was noted to be psychiatrically stable and, as such, had not required an alteration to her treatment plan in some time. There was documentation of plans to reduce the number of allowable episodes of agitation via an adjustment of goals, but this had not yet occurred. Another individual, Individual #181, had experienced an exacerbation of psychiatric symptoms and was hospitalized in a psychiatric facility at the time of the monitoring visit.

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

Summary: High and improved performance on these two indicators was a result of the work of the Center's lead psychiatrist and her involvement with individuals, their IDTs, and their behavioral health services. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
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.	88% 7/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	0/1
24	The psychiatrist participated in the development of the PBSP.	100% 8/8%	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1

Comments:

23. The psychiatric documentation referenced the behavioral health target behaviors. The functional assessment discussed the role of the psychiatric disorder upon the presentation of the behaviors in seven examples. In one example, regarding Individual #181, functional behavior assessment included an incorrect diagnosis.

24. There was documentation of psychiatric participation for individuals with a PBSP. The review of the PBSP was noted in the psychiatric clinical documentation. This was good to see.

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:

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: Quarterly reviews were occurring timely as required and with sustained high performance this indicator might be moved to the category of requiring less oversight after the next review. In addition, quarterly review documentation contained the required content for all but one individual (for one aspect). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
33	Quarterly reviews were completed quarterly.	100% 7/7	1/1	1/1	1/1	1/1	N/A	1/1		1/1	1/1
34	Quarterly reviews contained required content.	86% 6/7	1/1	1/1	1/1	0/1	N/A	1/1		1/1	1/1
35	The individual's psychiatric clinic, as observed, included the standard components.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

33. Quarterly reviews were completed in a timely manner for all individuals requiring them. Individual #69 was a new admission to the facility as of June 2018 and, as such, his first quarterly psychiatry clinic was pending.

34. The Monitoring Team looks for nine components of the quarterly review. Six of the examples included all the necessary components. This was good to see. One evaluation was missing one required element: Individual #108 regarding non-pharmacological interventions.

35. Although this indicator is, and will remain, in less oversight, the Monitoring Team provides some additional positive commentary: During the monitoring visit, the facility psychiatrist was unavailable to conduct clinics. The statewide psychiatrist provided interim clinical services in her absence. Neuro-psychiatry clinic was observed for three individuals, two of these individuals were included in the review group. In addition, psychiatry clinic was observed for three individuals. The clinics were well run and comprehensive. The individuals, IDT members, and, in two cases, family members, were in attendance. In every clinic observation, a presentation was provided by each discipline that included specific data (e.g., behavioral targets, graphs, laboratory examinations). This was good to see.

Outcome 11 – Side effects that individuals may be experiencing from psychiatric medications are detected, monitored, reported, and addressed.												
Summary: Performance remained low. It may be that more clerical organization regarding these assessments would help in getting them completed. Given the other improvements in the psychiatry department, this should now be obtainable. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	38% 3/8	0/1	1/1	1/1	0/1	0/1	1/1		0/1	0/1
Comments: 36. There were delays in both the completion of the assessments and the prescriber review of the assessments. For example, regarding Individual #108, the prescriber did not review the AIMS dated 10/31/17. There was an AIMS performed 1/10/18 with the next assessment performed 5/10/1, the assessment should have been performed in April 2018. The MOSES was performed 9/29/17 with the following assessment performed 4/20/18. It should have been performed in March 2018.												

Outcome 12 – Individuals' receive psychiatric treatment at emergency/urgent and/or follow-up/interim psychiatry clinic.												
Summary: Emergency clinics were not currently available for individuals because there was no onsite provider available to see individuals. The Center demonstrated that it was able to access services if necessary, and during the visit, the State Office psychiatrist discipline coordinator travelled to the Center and provided psychiatric treatment, including clinical encounters that were scheduled for the week of the monitoring visit.			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: These indicators remain in active monitoring.			Individuals:									
#	Indicator	Overall	135	192	170	108	69	187	134	198	181

		Score									
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		1/1	1/1
42	There is a treatment program in the record of individual who receives psychiatric medication.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1		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
Comments:											

Outcome 14 – For individuals who are experiencing polypharmacy, a treatment plan is being implemented to taper the medications or an empirical justification is provided for the continued use of the medications.											
Summary: Justification existed for polypharmacy regimens for all individuals for this review and for the previous two reviews, too (with one exception). Therefore, indicator 44 will be moved to the category of requiring less oversight. With sustained high performance, the same might occur for indicator 45 after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
44	There is empirical justification of clinical utility of polypharmacy medication regimen.	100% 6/6	1/1	N/A	1/1	N/A	1/1	1/1		1/1	1/1
45	There is a tapering plan, or rationale for why not.	100% 6/6	1/1	N/A	1/1	N/A	1/1	1/1		1/1	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 six individuals. Polypharmacy justification was appropriately documented in six examples. The psychiatrist did a good job of reviewing the regimens in the psychiatric clinical documentation. This was good to see.

45. There was documentation for six individuals who met criteria for polypharmacy showing a plan to taper various psychotropic medications or documentation of why this was not being considered. This documentation was located either in the psychiatric documents or in the polypharmacy meeting minutes.

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 good goals and reliable data. As such, an assessment of progress could be made and he was determined to be making progress. This was good to see. For the other individuals, either progress was not occurring or there were insufficient/unreliable data. For some individuals who were not progressing, actions were taken and implemented; for others, this was not the case. This set of indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
6	The individual is making expected progress	14% 1/7	0/1	0/1	0/1	0/1	N/A	0/1	N/A	1/1	0/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	0% 0/1	N/A	N/A	N/A	0/1	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.	40% 2/5	0/1	1/1	0/1	N/A	N/A	1/1	N/A	N/A	0/1
9	Activity and/or revisions to treatment were implemented.	100% 2/2	N/A	1/1	N/A	N/A	N/A	1/1	N/A	N/A	N/A

Comments:
6. Individual #135, Individual #192, Individual #170, Individual #187, and Individual #181 were not making progress. Individual #198's data were demonstrated to be reliable and he was making progress. Individual #108 was also progressing, however, she was scored as 0 because her data were not demonstrated to be reliable (see indicator 5). Individual #69 had insufficient data to determine if he was progressing.

7. Individual #108's physical aggression and SIB objectives were achieved in May 2018, however, they were not updated.

8-9. Individual #192 and Individual #187 were not making expected progress, however, their progress notes included actions to address the absence of progress. Individual #135, Individual #170, and Individual #181's progress notes also indicated they were not progressing, however, their progress notes did not include any corrective actions to address the lack of progress.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.	
Summary: An area of focus for El Paso SSLC is to ensure that all staff are trained in PBSPs. PBSP versions for float staff were available. With sustained high performance, indicators 17 and 18 might be moved to the category of requiring less	Individuals:

oversight after the next review. These three indicators will remain in active monitoring.											
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
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.	14% 1/7	0/1	0/1	0/1	0/1	0/1	1/1	N/A		0/1
17	There was a PBSP summary for float staff.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A		1/1
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A		1/1
Comments: 16. Individual #187 had documentation that at least 80% of direct support professionals (DSPs) implementing their PBSPs were trained on its implementation.											

Outcome 6 – Individuals' progress is thoroughly reviewed and their treatment is modified as needed.											
Summary: Data were presented at clinical meetings and peer review meetings. Follow-up occurred after peer review meetings. This was the case at El Paso SSLC for the previous two reviews, too. Therefore, indicators 21 and 22 will be moved to the category of requiring less oversight. It was good to see improvement in behavioral health progress notes and graphic summaries as well as occurrence of internal and external peer review.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
19	The individual's progress note comments on the progress of the individual.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A		1/1
20	The graphs are useful for making data based treatment decisions.	100% 7/7	1/1	1/1	1/1	1/1	1/1	1/1	N/A		1/1
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.	100% 2/2	N/A	N/A	N/A	1/1	1/1	N/A	N/A		N/A
22	If the individual has been presented in peer review, there is evidence of documentation of follow-up and/or implementation of recommendations made in peer review.	100% 1/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A		1/1
23	This indicator is for the facility: Internal peer reviewed occurred at least three weeks each month in each last six months, and external	100%									

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

Comments:
19. All individuals had complete progress notes. This represents an improvement over that last review when 14% of individuals had consistent progress notes.

21. In order to score this indicator, the Monitoring Team observed Individual #108 and Individual #69'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 #181's peer review minutes were used to score this indicator. The minutes from his 3/2/18 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 3/21/18 peer review meeting.

23. There was documentation that El Paso SSLC conducted weekly internal and monthly external peer review meetings. This represents another improvement from the last review when regular peer review was not being implemented.

Outcome 8 – Data are collected correctly and reliably.

Summary: Indicator 30 scored higher than in any previous review. Continued attention to the PBSP data collection components should result in continued improvement. Indicator 30 will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
26	If the individual has a PBSP, the data collection system adequately measures his/her target behaviors across all treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
27	If the individual has a PBSP, the data collection system adequately measures his/her replacement behaviors across all treatment sites.										
28	If the individual has a PBSP, there are established acceptable measures of data collection timeliness, IOA, and treatment integrity.										
29	If the individual has a PBSP, there are established goal frequencies (how often it is measured) and levels (how high it should be).										
30	If the individual has a PBSP, goal frequencies and levels are achieved.	71% 5/7	1/1	1/1	1/1	0/1	1/1	0/1	N/A		1/1

Comments:
30. Goal frequencies and levels of DCT, IOA, and treatment integrity were achieved for Individual #135, Individual #192, Individual #170, Individual #69, and Individual #181. This represents another improvement from the last review when one individual achieved their goal frequencies and levels of DCT, IOA, and treatment integrity. Individual #187's IOA, DCT, and treatment integrity frequency

goal was monthly, and there were no assessments in June 2018. Individual #108's most recent IOA level was below 80%.

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 clinically relevant outcomes related to chronic and/or at-risk conditions requiring medical interventions. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
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 #187 – seizures, and constipation/bowel obstruction; Individual #170 – diabetes, and weight; Individual #32 – infections, and diabetes; Individual #118 – other: Vitamin D deficiency, and GI problems; Individual # 155 – constipation/bowel obstruction, and other: breast cancer; Individual #58 – osteoporosis, and other: anemia; Individual #115 – seizures, and infections; Individual #177 – diabetes, and other: chronic back pain; and Individual #107 – cardiac disease, and GI problems). None of the related 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 provision of medical supports and services to these nine individuals.

Outcome 4 – Individuals receive preventative care.											
Summary: Three of the nine individuals reviewed received the preventative care they needed. Given the importance of preventative care to individuals' health, these indicators will continue in active oversight until improvement is noted and the Center's quality assurance/improvement mechanisms related to preventative care can be assessed, and are deemed to meet the requirements of the Settlement Agreement. In addition, the Center needs to focus on ensuring medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual receives timely preventative care:										
	i. Immunizations	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
	ii. Colorectal cancer screening	60% 3/5	N/A	N/A	0/1	N/A	1/1	0/1	1/1	N/A	1/1
	iii. Breast cancer screening	100% 2/2	N/A	N/A	N/A	N/A	1/1	1/1	N/A	N/A	N/A
	iv. Vision screen	56% 5/9	1/1	0/1	0/1	0/1	1/1	1/1	1/1	1/1	0/1
	v. Hearing screen	63% 5/8	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	N/A
	vi. Osteoporosis	71% 5/7	N/A	0/1	0/1	1/1	1/1	1/1	1/1	N/A	1/1
	vii. Cervical cancer screening	0% 0/2	N/A	N/A	N/A	N/A	0/1	0/1	N/A	N/A	N/A
b.	The individual's prescribing medical practitioners have reviewed and addressed, as appropriate, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic as well as endocrine risks, as applicable.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. The following problems were noted:

- For Individual #170:
  - The AMA stated that the DEXA scan from 2014 showed osteopenia, but did not specify the site. The plan was to continue Vitamin D supplements and check levels. The FRAX score was not calculated to determine if additional therapy was indicated, and the plan to repeat the DEXA was not specified. In its response to the document request, the

Center indicated that the DEXA was not applicable and no report was submitted.
    - The date of his last vision assessment was not documented.
- For Individual #32:
    - On 7/31/15, his last vision exam was completed. He was prescribed Seroquel, which requires yearly eye evaluations.
    - On 10/4/11, he had his last DEXA scan.
    - On 5/5/14, he had his last hearing screening.
    - On 10/22/16 he had a colonoscopy. The report indicated he had stool in the entire colon. "Repeat colonoscopy is not recommended recommendations are n0t applicable since this was not for colon cancer screening or surveillance." The Center did not submit colon cancer screening information.
- On 4/1/16, Individual #118 had her last eye exam, and it was related to cellulitis of the eyelid. Although an audiology exam was attempted on 7/28/18, the report indicated testing could not be completed.
- For Individual #58:
    - With regard to a colonoscopy, the Center submitted a refusal and waiver, but documented that the Legally Authorized Representative (LAR) refused to sign it.
    - On 7/1/15, she had her last hearing screening.
    - In 2012, she had her last pap test and well woman exam. The gynecologist consultation stated she needed a pap every three years, and a gynecology exam yearly.
- On 5/9/16, Individual #107's last vision exam was completed.

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

Outcome 5 – Individuals with Do Not Resuscitate Orders (DNRs) that the Facility will execute have conditions justifying the orders that are consistent with State Office policy.

Summary: N/A			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual with DNR Order that the Facility will execute has clinical condition that justifies the order and is consistent with the State Office Guidelines.	N/A									
Comments: a. None											

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.											
Summary: 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, for the individuals reviewed, although IDTs often held post-hospital ISPA meetings, the PCPs did not always attend, and ISPAs did not fully address follow-up medical and healthcare supports to reduce risks and promote early recognition. The Monitoring Team will continue to review the remaining indicators.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
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.	36% 4/11	1/2	1/2	N/A	1/1	N/A	0/1	0/2	0/2	1/1
b.	If the individual receives treatment for the acute medical issue at the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency consistent with the individual's status and the presenting problem until the acute problem resolves or stabilizes.	27% 3/11	0/2	1/2		0/1		1/1	0/2	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.	57% 4/7	N/A	1/2	1/2	1/2	N/A	N/A	1/1	N/A	N/A
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	50% 2/4		1/1	0/2	1/1			N/A		
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.	57% 4/7		1/2	2/2	1/2			0/1		
f.	If individual is transferred to the hospital, PCP or nurse communicates necessary clinical information with hospital staff.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
g.	Individual has a post-hospital ISPA that addresses follow-up medical and healthcare supports to reduce risks and early recognition, as	60% 3/5		1/2	1/2	N/A			1/1		

	appropriate.										
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.	43% 3/7		1/2	0/2	2/2			0/1		

Comments: a. For seven of the nine individuals reviewed, the Monitoring Team reviewed 11 acute illnesses addressed at the Center, including: Individual #187 (cellulitis/human bite on 5/28/18, and lip swelling on 8/2/18), Individual #170 (left hand cellulitis on 4/25/18, and constipation on 2/12/18), Individual # 118 (Stage 2 pressure ulcer on 4/4/18), Individual #58 (emesis on 4/10/18), Individual #115 (fall with injuries on 5/15/18, and bronchitis and cellulitis on 7/2/18), Individual #177 (back pain and bite to left arm due to altercation with peer on 3/14/18, and gastroenteritis on 3/7/18), and Individual #107 [upper respiratory infection (URI) on 3/23/18].

PCPs assessed the following acute issues according to accepted clinical practice: Individual #187 (lip swelling on 8/2/18), Individual #170 (left hand cellulitis on 4/25/18), Individual # 118 (Stage 2 pressure ulcer on 4/4/18), and Individual #107 (URI on 3/23/18).

b. For Individual #170 (left hand cellulitis on 4/25/18), Individual #58 (emesis on 4/10/18), and Individual #107 (URI on 3/23/18), the PCPs 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 5/26/18, nursing staff documented that another individual bit Individual 187 on the face. The nurse notified the PCP. On 5/29/18, the PCP evaluated the individual. The diagnosis was bite wound and cellulitis. The plan was to check for blood borne pathogens (BBPs) and prescribe Keflex, but the PCP did not specify which BBPs would be checked. It should be noted that first-generation cephalosporins, such as Keflex, do not cover the common oral pathogens, which are Beta lactam producers. Additionally, it is important that interventions related to transmission of infectious diseases through blood and body fluids occur promptly. The window for providing post-exposure prophylaxis is narrow. Guidelines and timeframes related to post-exposure prophylaxis are available on the website of the Centers for Disease Control and Prevention.

  On 5/31/18, the PCP documented that the individual was at school and follow-up would occur the next day. On 6/1/18, the PCP noted that Individual #187's facial wound was healing, but did not document the results of the BBP screening. On 6/4/18, the PCP documented the wound was healing well, but provided no discussion of the serology results. On 7/25/18, the individual bit an employee. The PCP documented "will check BBP if not done in past 6 months." On 7/31/18, the PCP noted that the "first screen in June 2018" was negative.
- On 8/2/18, the PCP documented evaluating Individual #187 for a swollen lower lip with blisters. It was not clear if there was a history of trauma. The plan was to maintain good oral hygiene, use Chloraseptic mouthwash, and apply hydrocortisone cream. The individual was to return to clinic as needed. No documentation was found of resolution.
- On 2/12/18, nursing staff documented Individual #170 had not had a bowel movement (BM) in 72 hours. The nurse gave him prune juice. On 2/13/18, nursing staff documented no BM for 96 hours. Per nursing documentation, the "abdomen is distended." Nurses gave three doses of prune juice. The plan was: "Nurse to continue prune juice due to no available rectal

suppository available prn [pro re nata, or as needed]." Nurses did not document notification of the physician. It was not clear why nurses did not administer a suppository.

On 2/14/18, the PCP saw the individual in the clinic due to no BM in six days and for follow-up of left leg cellulitis. The PCP documented the individual's abdomen was distended and firm with sluggish bowel sounds. The assessment was constipation/obstipation and the plan was to check a KUB (i.e., abdominal x-ray), give a suppository, and follow-up. On 2/15/18, the PCP made an IPN entry with the results of the KUB: possible moderate to large amount of abdominal and pelvic ascites versus artifact. Therefore, the individual went for a repeat KUB and abdominal ultrasound. Later that day, the PCP documented that Individual #170 was evaluated at the wound clinic and had an ultrasound that showed no free fluid. The KUB showed persistent dilation of colonic bowel loops. Notes indicated the individual had a significant BM with magnesium citrate. The plan was to start bisacodyl suppositories for the next three days.

The PCP did not document any follow-up. On 3/1/18, nursing staff documented no BM since 2/26/18, with prune juice given. On 3/12/18, nursing staff again reported no BM for 72 hours. Records continued to document issues related to bowel elimination. Below, Individual #170's ED visit for bowel obstruction is discussed.

- On 4/25/18, Individual #118's PCP documented a pimple on her right buttock. The next PCP note was on 5/25/18. It documented that the right hip wound was due to pressure against a bony prominence. There was no staging of the wound. On 5/29/18, the PCP evaluated the individual for right foot swelling, but did not comment on pressure ulcer.
- On 5/15/18, Individual #115's PCP evaluated him due to multiple injuries associated with a possible fall the previous night. The physical exam revealed a 2-centimeter (cm) superficial laceration of the left parietal region, notable edema to the left mastoid region with redness, swelling of the nose, and abrasions to the chest wall. Redness also was present under the left eyelid. The plan was to check x-rays. The scalp laceration was cleaned and dressed.

  On 5/18/18, another PCP documented that the individual was seen on 5/17/18, and was in his usual state of health. The scalp laceration was healing well, but the exam did not address the other documented injuries. Per the PCP, the "x-ray rib series showed indeterminate fractures (these are new findings as previous x-rays showed similar findings)." It was unclear what this meant. The PCP did not document the results of the other x-rays.

  On 5/30/18, the PCP documented the next assessment. At that time, Individual #115 was transferred to the ED for evaluation of respiratory distress.
- On 7/2/18, the PCP saw Individual #115 due to fatigue and congestion. The lung exam was pertinent for diminished coarse breath sounds. The individual's oxygen saturation varied from 87% to 89%. The assessment was hypoxia secondary to chronic bronchitis. The plan was to start oxygen, provide nebulizer treatments and check stat labs. Follow-up was scheduled for two days.

  On 7/3/18, nursing staff documented swelling and edema in the individual's left foot. The PCP was contacted and prescribed Keflex for treatment of possible cellulitis (individual had a chronic left foot wound).

  The PCP did not evaluate the individual again until 7/5/18. The hypoxia was documented as resolved. The cellulitis of the foot

reportedly was improving. However, the PCP had not documented a baseline examination to establish improvement. The labs, done on 7/2/18, showed a significant increase in the white blood cell count (15.74) and an elevated blood urea nitrogen (BUN). The PCP recommended increased fluid intake to address dehydration. The plan included repeating a Modified Barium Swallow Study (MBSS) to reassess dysphagia and follow-up in five days. On 7/9/18, the PCP saw him again for excessive secretions and coughing. The plan was to give Robitussin and complete the MBSS.

On 7/17/18, the PCP documented that the SLP was requesting a clearance chest x-ray (CXR) to restart oral feedings after the MBSS. The PCP did not indicate the findings of the MBSS. On 7/19/18, the PCP documented CXR findings with bilateral fibrotic changes greatest in the bases. The PCP approved oral intake.

The next PCP assessment, on 7/30/18, addressed a blister of the right foot. On 8/14/18, Individual #115 was admitted to the hospital again with a diagnosis of aspiration pneumonia. The hospital's attending physician recommended placement of a jejunostomy tube (J-tube).

- On 3/14/18, Individual #177 was involved in an altercation with another individual. On 3/15/18, the PCP saw him for evaluation of back pain. He also sustained a bite to the left arm.

  The documentation of the physical exam of the back was "tenderness of lumbosacral spine and paravertebral tissue bilaterally, although L>R." This was a very limited exam for an individual with a history of lumbar radiculopathy and neural foraminal stenosis. Documentation of a thorough neurological exam was indicated due to his complaints of back pain exacerbated by an altercation in which he was also restrained. The plan for the back injury was to prescribe Flexeril, use a back brace, and consult orthopedics.

  On 3/19/18, the PCP reassessed Individual #177, at which time the PCP documented persistent tenderness with restricted range of motion. The PCP did not document the presence or absence of neurologic symptoms, such as leg pain, numbness, weakness, or bowel/bladder incontinence. The PCP did not document the necessary physical neurologic exam for assessment of back pain. On 4/18/18, Individual #177 was eventually evaluated for pain management. However, it was not clear that the recommendations were fully implemented, and the PCP provided no documentation of a rational for not doing so.
- On 3/7/18, the PCP documented that since the previous day, Individual #177 experienced eight loose stools. There were no reports of nausea, vomiting or abdominal pain. The physical exam included the heart, lungs, and abdominal exam. There was no assessment of volume status for this individual with significant diarrhea. The assessment was acute gastroenteritis and the plan was to continue clear liquids, check stool for the Nora virus, and follow-up in three days. On 3/8/18, nursing staff documented that the individual had another loose stool with blood and abdominal discomfort. On 3/9/18, the individual was seen in clinic. The abdominal exam was normal. He refused rectal examination. The individual's heart rate was elevated at 112 and the blood pressure was normal. The plan was to obtain a gastroenterology (GI) consult and follow-up after the consult was done. There was documentation of GI blood loss in an individual with a two-day history of diarrhea and tachycardia. However, the PCP did not order a complete blood count (CBC) or electrolytes. Moreover, there was no documentation of follow-up. On 4/2/18, the individual complained again of bloody stools, but the rectal exam was negative.

c. For four of the nine individuals reviewed, the Monitoring Team reviewed seven acute illnesses/occurrences that required

hospitalization or an ED visit, including those for Individual #170 (left leg cellulitis on 2/1/18, and bowel obstruction on 4/28/18), Individual #32 (finger amputation on 3/27/18, and cellulitis, hypernatremia, and dehydration on 3/30/18), Individual #118 (fecal impaction, hypernatremia, and dehydration on 4/1/18, and fecal impaction on 4/3/18), and Individual #115 (aspiration pneumonia on 5/30/18).

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

- It was positive to see that the following individual displaying signs/symptoms of acute illness received timely acute medical care, and follow-up care: Individual #118 (fecal impaction on 4/3/18).
- On 2/1/18, the PCP documented that at 8:45 a.m., another PCP indicated that Individual #170 had left leg swelling. The assessment was cellulitis of the left leg that was rapidly spreading. The PCP referred the individual to the ED for evaluation. At 11:00 a.m., the original PCP documented a note stating that at 8:15 a.m., the PCP saw the individual and noted multiple bullae. Forty minutes later, the leg began to swell and have erythema. The individual was transferred to the ED for evaluation.

  On 2/8/18, the individual returned, and on 2/9/18, the PCP saw him. The hospital diagnosis was left leg cellulitis. The next PCP follow-up was on 2/12/18. At that time, the PCP documented that the left leg had less redness and edema: "Hygiene lacking. Feet with callouses and cracking bilaterally, right worse than left." The PCP noted peeling and cracking of the skin between the individual's toes, and plantar surfaces very thickened and cracking on heels. The plan was to consult a wound care specialist and prescribe Lamisil for tinea pedis.

  On, 2/9/18, the IDT held an ISPA meeting, but the PCP did not attend. The IDT noted that the lack of proper foot care increased the individual's risk for infection, but did not specifically address foot hygiene and care.

  On 2/14/18, the PCP saw Individual #170 for evaluation of constipation. The PCP never documented resolution of the cellulitis. On 5/22/18, the PCP assessment noted that the heels had severe cracking and calluses. The individual refused to attend podiatry clinic.
- For Individual #170, nurses noted:
  - On 4/25/18 - No BM x 48 hours - two cans prune juice; refused suppository;
  - On 4/26/18 - No BM - five cans of prune juice;
  - On 4/27/18 - No BM in 72 hours - two cans of prune juice and enema; and
  - On 4/28/18 - No BM; enema.

  On 4/26/18, the PCP evaluated the individual for cellulitis, but did not document any discussion of constipation.

  On 4/28/18, at around 3:30 p.m., the individual had an extra-large emesis. The abdomen was noted to be hard and distended. At around 5:30 p.m., the PCP was notified that the individual refused meals, had no BM in 120 hours (i.e., five days), and had emesis. The PCP ordered an enema. The individual vomited following administration of the enema. Around 6:30 p.m., the PCP gave an order to transfer the individual to the ED for evaluation. The transfer occurred at approximately 8:50 p.m. This was an after-hours transfer, but the PCP did not write a note on 4/29/18.

A computed tomography (CT) scan of the abdomen was completed and showed a large bowel obstruction secondary to a rectal fecal impaction. After having multiple bowel movements in the ED, the individual was discharged. On 4/29/18, at 1:00 p.m., he returned to the Center. On 4/30/18, the PCP evaluated the individual.

According to the PCP, the individual did not have good stooling habits at home, and the PCP referred this issue to the IDT for review. It was not clear what, if any, changes were made to the bowel management regimen. On 5/1/18, the PCP reassessed the individual. The plan was to encourage a high-fiber diet and fluids and consult Behavioral Health Services (BHS) regarding abnormal toileting habits. The PCP prescribed Glycerin suppositories, and nurses were to administer them, if the individual had no BM in 48 hours. The PCP also documented that the cellulitis in the individual's left hand was resolving.

Per the PNMT review, dated 5/2/18, the PNMT considered the root cause of the bowel obstructions to be "the tendency to avoid using the restroom when he experiences the urge to defecate resulting in fecal impaction." This did not address the true root cause, because the PNMT should have attempted to continue to ask "why?" (e.g., why did he avoid using the restroom?). BHS was to consider strategies to promote use of the restroom.

- According to nursing documentation, on 3/27/18, at around 11 a.m., Individual #32 was found with a partial amputation of the left fourth finger. The fingertip was placed in a bag, the finger wrapped, and the individual was transferred to the ED. The PCP was present and requested the transfer, but did not document an evaluation. At approximately 7:00 p.m., the PCP documented a note stating the amputation was a result of closing a bathroom door on the finger.

  On 3/28/18, the PCP conducted follow-up. The individual had a left fingertip avulsion and was treated by orthopedics. On 3/29/18, he was scheduled to follow up with orthopedics. On 3/29/18, the PCP did not conduct follow-up.

  The PCP's next assessment was on 3/30/18. This evaluation was due to swelling of the left index and third fingers. Cutaneous vesicles of the fingers were documented. An x-ray showed a fracture of the 2nd metacarpal of uncertain age. The individual was sent to ED for evaluation of a possible fracture. He was admitted with cellulitis of left hand, hypernatremia, dehydration, acute kidney injury, and failure to thrive. He was subsequently transferred to Intensive Care Unit (ICU).

  On 4/9/18, Individual #32 returned to the Center, and on 4/10/18, the PCP saw him. The PCP documented that the individual was admitted with a sodium of 163 and BUN of 44, due to decreased oral intake. On 4/4/18, the individual had a percutaneous endoscopic gastrostomy (PEG) tube placed. The PCP did not document that this individual was transferred to the Intensive Care Unit, which would be important information to provide in the post-hospital assessment. (This note was verified on 6/21/18.) The PCP did not document additional follow-up. The next PCP entry was on 4/13/18, and was related to a failed eye appointment. The next PCP entry that involved assessment of the individual was on 5/3/18. It noted a new nail matrix was developing.

  On 4/10/18, the IDT held an ISPA meeting. Notes prior to this transfer did not document issues related to oral intake or a change in mental status. Yet, he was transferred to the ICU with severe dehydration and hypernatremia. The ISPA did not adequately address this concern.
- On 3/27/18, Individual #118's PCP documented that nursing staff referred her to the clinic because of pain concerns, meal

refusals, and decreased stools. The physical exam was unremarkable. The plan was to monitor anorexia, encourage fluids, and order a KUB. The assessment did not address volume status for an individual who was refusing meals. The heart rate and urine output were not documented. The carbon dioxide on the chemistries was low at 20 and the white blood cell count was slightly elevated.

On 3/29/18, the PCP recorded the results of the KUB: severe dextroscoliosis of the thoracic and lumbar spines and severe constipation. The rectum was distended up to 9.5 centimeters (cm). The PCP ordered manual removal of the impaction and an enema if needed after dis-impaction. The PCP did not address the abnormal labs and did not document the effectiveness or lack thereof of the nursing interventions (enemas and suppository).

On 4/1/18, the PCP was notified that the individual had a heart rate of 125. Orders were given for a suppository and enema. The individual had not had a BM in 72 hours. The PCP documented that the individual was evaluated and found to have a heart rate of 108. The abdomen was soft with hypoactive bowel sounds. The plan was to check a KUB. At around 6:30 p.m., the PCP was notified that the individual had a severe ileus on KUB. The individual was transferred to the hospital after hours, but the PCP did not write a note within one business day.

On 4/2/18, at approximately 7:00 p.m., Individual #118 returned to the Center. On 4/3/18, the PCP evaluated the individual, and summarized the events leading up to the transfer: the individual had a history of being irritable and refusing meals for several days. On 3/29/18, nursing staff had performed a manual dis-impaction, but the individual did not have any additional bowel movements. Emesis was documented on 3/31/18. On 4/1/18, a suppository and enema produced no results. The individual was subsequently transferred to the ED where enemas were given. She was diagnosed with hypernatremia, dehydration, and fecal impaction.

Per the PCP's post-hospital assessment, she had not returned to baseline, continued to have tachycardia, diaphoresis, and abdominal tenderness. At 8 p.m., she was sent back to ED for evaluation of an acute abdomen.

- On 5/30/18, at approximately 6:43 p.m., the PCP made an IPN entry stating that Individual #115 was "seen earlier in day" and had coarse breath sounds in the right lung. A CXR was ordered, but not done due to an off-campus clinic appointment. There was no IPN entry for this assessment.

  The PCP documented that the individual was being transferred to the ED for evaluation of acute respiratory distress and possible aspiration pneumonia. At approximately 6:44 p.m., he was transferred. This IPN entry did not appear to be based on an assessment at the time of transfer. The exam appeared to be a late entry for the exam that occurred earlier during the day. The documented plan was: "As per nursing assessment this pm, will transfer to UMC ER for further evaluation and supportive care."

  On 6/4/18, at approximately 1:16 p.m., Individual #115 returned to the Center, and the PCP saw him that day. His discharge diagnosis was aspiration pneumonia. During his hospitalization, he was transferred to telemetry due to hypotension and bradycardia. The plan was to continue antibiotics. On 6/25/18, the PCP made an addendum to this note and changed the diagnosis to pneumonia. On 6/5/18, the PCP documented that the individual remained nothing-by-mouth (NPO) with gastric

feedings only. His physical exam noted that he was “gaunt." The plan was to continue antibiotics and enteral nutrition with possible Speech Language Pathologist (SLP) reevaluation in 30 days. The PCP included no plan to address the 19.4-pound weight loss. On 6/6/18, a nursing note documented that all medications and meals were to be "PO" until Speech Therapy had assessed. The SLP note, dated 6/6/18, indicated that the individual would not receive anything by mouth for the next four weeks.

On 6/25/18, the PCP documented a follow-up assessment. The pneumonia was assessed as improved. Wound care was to continue for the "left foot nodule." Follow-up was as needed. There was no discussion regarding the neurologist’s recommendations from the consult, dated 6/12/18. There was also no discussion of the plan to address the weight loss. The previous note (6/5/18) included a plan to have SLP reassess the individual in four weeks, but the PCP did not document any discussion regarding the management of recurrent pneumonia. His current aspiration goals and actions were no longer relevant with his NPO status. The next PCP evaluation was on 7/2/18.

Outcome 7 – Individuals’ care and treatment is informed through non-Facility consultations.

Summary: Based on the Monitoring Team’s review of consultation documentation for review of other indicators, PCPs completed late reviews of more than half the consultations reviewed. As a result, Indicator b will move back to active monitoring. Although more work is needed, it was good to see that the Center focused on ensuring PCPs refer consultation recommendations to IDTs, when appropriate, and IDTs review the recommendations and document their decisions and plans in ISPAs.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
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, these indicators moved to the category requiring less oversight. However, based on the Monitoring Team’s review of consultation documentation for review of other indicators, PCPs completed late reviews of more than half the consultations reviewed. As a result, Indicator b will move back to active monitoring.									
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.	80% 4/5	1/1	N/A	1/2	N/A	N/A	N/A	1/1	1/1	N/A

Comments: For the nine individuals reviewed, the Monitoring Team reviewed a total of 18 consultations. The consultations reviewed included those for Individual #187 for gynecology on 8/2/18, and eye on 6/4/18; Individual #170 for neurology on 4/3/18, and

neurology on 5/29/18; Individual #32 for orthopedics on 3/29/18, and neurology on 4/10/18; Individual #118 for ear, nose and throat (ENT) on 7/23/18, and GI on 6/18/18; Individual #155 for GI on 4/19/18, and orthopedics on 6/28/18; Individual # 58 for eye on 5/2/18, and podiatry on 5/24/18; Individual #115 for orthopedics on 6/5/18, and GI on 4/17/18; Individual #177 for orthopedics on 6/26/18, and pain clinic on 4/18/18; and Individual #107 for GI on 3/29/18, and endocrinology on 5/10/18.

b. Based on the Monitoring Team's review of consultation documentation for review of other indicators, PCPs completed late reviews of more than half the consultations reviewed. Often, these reviews were weeks late, and, at times, months overdue. As a result, Indicator b will move back to active monitoring.

e. For Individual #32's orthopedics consultation on 3/29/18, the PCP did not address the need to refer it to the IDT. This consultation was related to the partial amputation of his left fourth finger.

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

Summary: As indicated in previous reports, 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.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
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.	17% 3/18	0/2	0/2	0/2	1/2	1/2	1/2	0/2	0/2	0/2

Comments: For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review (i.e., Individual #187 – seizures, and constipation/bowel obstruction; Individual #170 – diabetes, and weight; Individual #32 – infections, and diabetes; Individual #118 – other: Vitamin D deficiency, and GI problems; Individual # 155 – constipation/bowel obstruction, and other: breast cancer; Individual #58 – osteoporosis, and other: anemia; Individual #115 – seizures, and infections; Individual #177 – diabetes, and other: chronic back pain; and Individual #107 – cardiac disease, and GI problems).

a. For the following individuals' chronic or at-risk conditions, PCPs conducted medical assessment, tests, and evaluations consistent with current standards of care, and the PCP identified the necessary treatment(s), interventions, and strategies, as appropriate: Individual #118 – GI problems, Individual # 155 – constipation/bowel obstruction, and Individual #58 – osteoporosis. The following provide examples of concerns noted:

- According to Individual #187's AMA, the assessment/plan was: "Last seizures were in 2009. Continue Zonisamide and Lamotrigine." The neurologist followed the individual every six months, and the PCP implemented the recommendations of the neurologist. However, the PCP provided no discussion regarding the need to have the neurologist evaluate for tapering of the antiepileptic drugs (AEDs). The AMA should provide the justification for continuing two seizure medications in an individual who had been seizure free for nine years.

- For Individual #187, nursing staff documented several episodes of constipation, based on a lack of a bowel movement for three days. Nurses administered prune juice, but it was not always effective. The individual required the use of acute interventions, such as suppositories, but the PCP made no change in the bowel management plan. Moreover, the AMA, completed on 3/1/18, did not include constipation as a diagnosis. The medication regimen included the use of PRN bisacodyl suppositories every three days. The interval medical review (IMR), signed on 8/6/18, did not list constipation as a diagnosis, even though the IPNs documented more than five episodes of constipation between April and July 2018.
- According to Individual #170's AMA, he was diagnosed with prediabetes/borderline diabetes. The plan was to continue to monitor his nutritional and weight status, and increase his physical activity. The plan did not include pharmacologic therapy. On 10/26/17, the individual's A1c was 5.5, and on 5/30/18, it was 5.7. There was no change in the medical plan. Per the American Diabetes Association (ADA) guidelines, lifestyle modifications should be implemented and consideration should be given to starting pharmacologic therapy for individuals with normal renal function who are less than 60 years of age. Additionally, the PCP should provide a specific target for weight loss (rather than say "monitor").
- For Individual #170, the AMA plan for the management of obesity was to continue a low-calorie diet and increase physical activity. The PCP provided no specific plan to achieve this. The PCP did not include a dietary evaluation in the plan.
- Individual #32 was a carrier of Hepatitis B. Per the AMA, the gastroenterologist recommended obtaining an ultrasound and alpha-fetoprotein every six months, deoxyribonucleic acid (DNA) viral load annually, and liver function tests (LFTs) every three months. In 2016, a CT scan showed no liver masses; it was reported that the individual refused imaging procedures. The GI consult, dated 2/5/18, stated that since 2013, the individual had Hepatitis B, but "unknown status at present."
- According to the AMA, Individual #32 had "borderline diabetes," which is not the correct term for prediabetes. His A1c improved from 5.9 to 5.2. The plan was to continue his current diet. The PCP provided no discussion regarding the treatment of prediabetes with medication. On 10/20/17, the individual's A1c was 5.8, and on 1/17/18, it increased to 6.2. The Center submitted incomplete laboratory data. Re-submitted lab data showed that on 6/27/18, the A1c was 5.3, and on 8/22/18, it increased to 5.5. The fluctuations in A1c appeared to be related to changes in weight. The PCP should monitor this closely and manage it based on ADA guidelines.
- According to Individual #118's AMA, on 2/8/17, her Vitamin D level was 31, and the plan was to continue Vitamin D. There was no plan related to follow-up. However, on 7/28/17, the repeat was 27 (per the IHCP), and on 4/20/18, the level was 47.7. Medical assessments should state the current/most recent Vitamin D level, the dose of supplementation, the target level, and the plan for monitoring.
- Individual #155 had a history of breast cancer with bilateral mastectomy. The plan was to continue monitoring with an annual ultrasound. In August 2017, the ultrasound was negative. The Assessment/Plan (A/P) section of the AMA did not provide the date of her cancer diagnosis, stage of cancer, or treatment beyond mastectomy (i.e., radiation or chemo). The guidelines for post-treatment follow-up are based on the stage of breast cancer. The date of the second mastectomy was not clear in the AMA.
- Individual #58 was diagnosed with anemia/leukopenia. The plan was to continue a multivitamin (MVI) and follow-up with internal medicine. The A/P should clearly indicate the etiology of leukopenia and anemia, but did not. She was prescribed a MVI with iron, so it was not clear if she had an iron deficiency. If an iron deficiency has been documented, the PCP should clearly state the etiology.
- According to Individual #115's AMA, he continued to have intermittent lip quivering. He had a vagus nerve stimulator (VNS). The plan was to continue medications, follow-up with neurology as scheduled, and continue to follow the nursing care plan for seizures.

On 3/6/18, the neurologist noted no seizures, but documented lip quivering. The neurology consult, dated 6/12/18, noted that the individual had a long history of intractable epilepsy and was on three AEDs. During the neurology clinic, the Habilitation Therapies representative, Registered Nurse Case Manager (RNCM), and the direct care nurse provided conflicting data regarding lethargy and seizure activity. The recommendation was to obtain accurate seizure data and refer Individual #115 for cardiology evaluation and follow-up in three weeks. On 7/10/18, the neurologist recommended evaluation for myasthenia gravis. It was not until 7/26/18, that the PCP documented follow-up on the neurologist's recommendations.

- Per Individual #115's AMA, he was "Seen by Public Health in 2013 and indicated that he does not need any treatment for latent TB [tuberculosis]." The AMA did not include any information about follow-up assessments. Per the Center for Disease Control (CDC) guidelines, individuals should be instructed to report signs and symptoms of TB early. CXRs are no longer required, but individuals should be monitored for TB symptoms. An annual TB questionnaire should be completed.
- Per the AMA, dated 7/26/18, pain management and orthopedics followed Individual #177 for chronic back pain and degenerative joint disease of the right hip and left knee. The etiology of the chronic back pain was not documented in the A/P section of the AMA.

  Documentation showed he previously received back injections. The PCP provided no discussion of his home program for pain management, including, for example, the implementation of home Physical Therapy (PT)/exercise, and/or use of modalities such as heat, transcutaneous nerve stimulation, and topical non-steroidal anti-inflammatory drugs (NSAIDS). The A/P should indicate the etiology of the back pain, current status, and the treatment plan. Simply stating that he is being followed by specialists is not sufficient. Individual #177 continued to complain of back and joint pain, and frequently requested opioids for pain management.
- Individual #177 had a history of uncontrolled T2DM. He was followed by endocrinology. The last consult was on 3/7/18. The plan at that time was to place a continuous glucose monitor (CGM) and return to clinic in three months. On 3/27/18, a CGM was placed. However, the individual removed the CGM and there was no documentation of a follow-up appointment with endocrinology.
- According to the AMA, cardiology followed Individual #107 for hypertension, mitral regurgitation, and hyperlipidemia. In October 2017, he had his last cardiology evaluation. According to the AMA, the individual's hypertension was well controlled on metoprolol. The plan was to continue metoprolol. The AMA did not include any information on monitoring for target organ damage. There was no target blood pressure or blood pressure-range specified in the medical assessments. The hyperlipidemia was managed with Simvastatin and the individual's low-density lipoprotein (LDL) was 83. He also had moderate to severe mitral regurgitation and was not a candidate for surgery. Per the AMA, cardiology recommended antibiotic prophylaxis prior to dental work. This recommendation was not consistent with the 2007 American Heart Association (AHA) guidelines on infective endocarditis and the 2014 AHA/American College of Cardiology (ACC) valvular heart disease guidelines. The PCP should clarify the recommendation with the cardiologist. The AMA also did not specify whether or not the individual exhibited symptoms associated with moderate to severe mitral regurgitation. It also should be noted that the individual had poor oral hygiene and did not have appropriate dental treatment. It is recommended that individuals with valvular heart disease have meticulous oral hygiene and removal of plaque.
- According to Individual #107's AMA, the plan for the diagnosis of a hiatal hernia was to follow-up with GI as scheduled, and continue omeprazole. The PCP did not include any information on the type of hiatal hernia. It was not clear if the individual

had symptomatic gastroesophageal reflux disease (GERD).

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. However, for those that included medical action steps, documentation was found to show implementation those assigned to the PCPs. This indicator will remain in active oversight until full sets of medical action steps are included in IHCPs, and PCPs implement them.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	100% 2/2	N/A	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A
Comments: a. As noted above, individuals' IHCPs often did not include a full set of action steps to address individuals' medical needs. However, action steps assigned to the PCPs were implemented for the following: Individual #118 – other: Vitamin D deficiency, and Individual #58 – osteoporosis.											

Pharmacy

Outcome 1 – As a result of the pharmacy's review of new medication orders, the impact on individuals of significant interactions with the individual's current medication regimen, side effects, and allergies are minimized; recommendations are made about any necessary additional laboratory testing regarding risks associated with the use of the medication; and as necessary, dose adjustments are made, if the prescribed dosage is not consistent with Facility policy or current drug literature.											
Summary: N/R			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	If the individual has new medications, the pharmacy completes a new order review prior to dispensing the medication; and	Not rated (N/R)									
b.	If an intervention is necessary, the pharmacy notifies the prescribing practitioner.	N/R									
Comments: The Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved, these indicators are not being rated.											

Outcome 2 – As a result of the completion of Quarterly Drug Regimen Reviews (QDRRs) and follow-up, the impact on individuals of adverse reactions, side effects, over-medication, and drug interactions are minimized.											
Summary: Given that during this review and the past two reviews, practitioners generally implemented agreed-upon recommendations included in QDRRs (Round 12 – 91%, Round 13 – 100%, and Round 14 - 83%), Indicator d will be placed in the category requiring less oversight. The remaining indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	QDRRs are completed quarterly by the pharmacist.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
b.	The pharmacist addresses laboratory results, and other issues in the QDRRs, noting any irregularities, the significance of the irregularities, and makes recommendations to the prescribers in relation to:										
	i. Laboratory results, including sub-therapeutic medication values;	67% 12/18	1/2	2/2	1/2	2/2	2/2	2/2	2/2	0/2	0/2
	ii. Benzodiazepine use;	94% 17/18	2/2	2/2	1/2	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% 8/8	2/2	2/2	2/2	N/A	N/A	N/A	N/A	2/2	N/A
	v. Anticholinergic burden.	100% 8/8	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, these indicators 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.	92% 11/12	N/A	2/2	2/2	2/2	2/2	1/1	1/2	N/A	1/1
e.	If an intervention indicates the need for a change in order and the	N/R									

	prescriber agrees, then a follow-up order shows that the prescriber made the change in a timely manner.										

Comments: b. The following provide examples of problems noted:

- For Individual #187, the most recent lab data available had not been incorporated into the QDRR report.
- Individual #32's August 2018 QDRR noted that his last eye exam occurred in 2015, but included no recommendation to update it due to the use of Seroquel.

  In its comments on the draft report, the State disputed this finding, and stated: "Reference document TX-EP-1810-II.09, metabolic syndrome section (page 8 and 16) states that the last eye exam was on 7/31/15, a repeat consult was ordered on 3/8/18, however was unable to be seen due to behavior and Dr… will defer until behavior improves. Pharmacist noted that the eye exam was outdated, but it was previously ordered and currently in deferment due to inability to perform." The Clinical Pharmacist made a comment under metabolic syndrome regarding the eye exam. It stated that the PCP considered this exam to be elective and not urgent. The following statement is found in the manufacture's package insert as well as the FDA website: "Quetiapine was associated with the development of cataracts in animal studies. Lens changes have also been observed with long term therapy in humans, however a causal relationship has not been established. Nevertheless, examination of the lens by methods adequate to detect cataract formation is recommended upon initiation of quetiapine or shortly thereafter and at six-month intervals during chronic treatment." Thus, a proper ocular examination is not considered elective when the individual is treated with quetiapine. The Center's lab matrix states that an eye exam (with quetiapine use) should be done annually if the individual is age 40 or greater and biannually if less than 40 years of age. Thus, the lab matrix is not consistent with the FDA approved manufacture's recommendations. The Clinical Pharmacist should have alerted the PCP to this requirement for eye exams with use of the drug.

  In addition, his A1c appeared to fluctuate with weight changes, but the Pharmacist did not recommend a repeat when on 6/27/18, it was 5.3, which placed him out of the pre-diabetes range. When it was next tested on 8/22/18, his A1C increased to 5.5.

  In its comments on the draft report, the State disputed this finding, and stated: "Reference document TX-EP-1810-II.09, metabolic syndrome section (page 7) states weights for the quarter (Aug 150.5, Jul 151, June 151), as stated in report HbA1c on 6/27/18 = 5.3% and on 8/22/18 = 5.5%. No evidence that A1c appeared to fluctuate with weight. Reference document TX-EP-1810-II.61 (page 25), last HbA1c (1/17/18) = 6.2% when weight was at 155 lbs., which is further evidence that weight did not correlate with HbA1c fluctuations. Per the Diabetes Standards of Care guidelines, in individuals previously diagnosed with pre-diabetes HbA1c should be monitored every year (or repeated every 3 years if tested normal). This is reiterated in the State Supported Living Center Diabetes Guidelines, that were reviewed by the independent monitors. Pharmacist would not recommend to repeat HbA1c in August when it was performed just 2 months prior." The Monitoring Team reviewed the monthly weights and all available A1c levels for this individual:

Date	Average Monthly Weight	A1c
September 2017	127	
October 2017	131	5.8 10/20/17

November 2017	140	
December 2017	157	
January 2018	157	6.2 1/17/18
February 2018	154	
March 2018	153	
April 2018	144	
May 2018	151	
June 2018	148	5.3 6/27/18
July 2018	150	
August 2018	150	5.5 8/22/18

The individual's A1c increased as he gained weight. The highest A1c correlated with the highest weight. As the individual's weight decreased, so did the A1c. The AMA reported an A1c of 5.9 in August 2016. This individual was at increased risk for development of hyperglycemia due to the use of quetiapine. The manufacturer documents in the package insert that blood glucose increases to hyperglycemic levels have been observed commonly with quetiapine in clinical trials. Epidemiological studies suggest an increased risk of treatment-emergent hyperglycemia related adverse reactions in patients treated with atypical antipsychotics. Patients should, therefore, have baseline and periodic monitoring of blood glucose. State Office guidelines do not provide specific guidance on management of individuals with prediabetes. This individual has obvious fluctuations in the A1c levels and is treated with a drug known to cause hyperglycemia. Annual testing, as suggested by the State's comments, would not be appropriate. It is also important to note that the Monitoring Team reviewed a draft of the guidelines referenced, and made a number of comments on them. The Monitoring Team has not endorsed the guidelines to which the State referred in its comments.

- Individual #107 had hypertension treated with medication, but had not had an electrocardiogram (EKG) since 2015. The Pharmacist had not made a recommendation to repeat it.

  In its comments on the draft report, the State disputed this finding, and stated: "Per JNC 8, standard guidelines for the management of high blood pressure, routine EKG monitoring is not recommended. In addition, the Standardized state guidelines for Hypertension, that were reviewed by the independent monitors, states an EKG only needs to be performed at baseline for all patients with newly diagnosed hypertension… Guidelines cited: American Medical Association. 2014 Evidence-Based Guidelines for the Management of High Blood Pressure in Adults: Report from the panel members appointed to the eighth joint national committee (JNC 8). JAMA 2014; 311(5):507-520…State Supported Living Center Hypertension Guidelines. Implementation date: August 2018." Again, it is important to note that the Monitoring Team reviewed a draft of the guidelines referenced, and made a number of comments on them. The Monitoring Team has not endorsed the guidelines to which the State referred in its comments. Moreover, it is incorrect to state that the JNC 8 guidelines do not recommend routine EKG monitoring. In fact, the fourteen-page report published in JAMA, which the State cites in support of this individual not requiring further EKG testing, does not comment on when an EKG or any other diagnostics should be performed. In addition, the State Office guidelines do not state that "an EKG only needs to be

performed at baseline for all patients with newly diagnosed hypertension." State Office guidelines specifically state that an EKG should be done at baseline when hypertension is diagnosed. This individual had hypertension, valvular heart disease, hyperlipidemia, and was treated with a beta blocker and a statin. The Clinical Pharmacist noted that the EKG in 2015 was abnormal, but made no recommendation to repeat this study.

To state or imply that this individual needs no further EKG testing is not congruent with the clinical facts. The Clinical Pharmacist should have made a recommendation to repeat the EKG, but did not. Moreover, it appeared that the Clinical Pharmacist was not using the most current information in the QDRR. The individual had an EKG done on 2/28/18. It was abnormal and showed right axis deviation (RAD). RAD can be caused by a number of cardiac abnormalities.

In addition, he had markedly abnormal labs, such as a K+ 6.2 on 5/2/18, but the Pharmacist made no comments or recommendations. There was no repeat value submitted in the documents submitted.

In its comments on the draft report, the State disputed this finding, and stated: "Reference document TX-EP-1810-II.09, prevention per protocol section (page 5), pharmacist did comment noting that the provider had repeated BMP due to high K result, within same sentence the follow-up lab (5/3/18) noted K at 4.3. In addition, reference document TX-EP-1810-II.12, progress note (page 86), Dr… stated K+ high most likely due to hemolysis, repeat BMP STAT. At a follow-up, reference document TX-EP-1810-II.12, progress note (page 84), Dr… noted CMP (5/3/18) within normal limits. Repeat BMP had already been ordered, and results were within normal limits, no further recommendations necessary." As part of its Tier II document request, the Monitoring Team requested labs for one year. The documents the Center submitted in response did not include a repeat potassium. The last K+ documented in the lab reports was 6.2 on 5/2/18. Multiple physicians documented on 5/3/18. The first note documented that the 6.2 K+ was likely due to hemolysis, but a stat repeat would be drawn. Later that day, another PCP made an IPN entry. It did not mention the hyperkalemia, but noted the CMP done on 5/3/18 was normal. It did not document the potassium level. In sum, the lab reports related to the repeat CMP were not submitted in the document request, and the Monitoring Team could not verify that the repeat potassium was normal.

- Individual #32's August 2018 QDRR did not provide comments regarding benzodiazepine use.

  In its comments on the draft report, the State disputed this finding, and stated: "Reference document TX-EP-1810-II.09, per the medication profile (page 1), individual is not on a benzodiazepine and did not receive a benzodiazepine for pre-sedation during the quarter. A comment would not be appropriate for an individual who had not received a benzodiazepine during the quarter reviewed. Comment would not have changed how the pharmacist or prescriber approached care of individual." In order to show that a review was completed (i.e., not overlooked), the Clinical Pharmacist should have indicated in the QDRR that the individual had not had any use of benzodiazepines in the quarter (e.g., N/A, or "none"), as she had done for other individuals.
- For Individual #177, the Pharmacist noted that the atherosclerotic cardiovascular disease (ASCVD) risk not calculated due to the individual being under the age of 40. Individuals with Type 2 diabetes mellitus (T2DM) are at very high risk of CVD events. Therefore, the ADA provides specific recommendations for individuals at age 40 years and/or with T1DM. Additionally, the risk of microvascular disease is increased. This individual had an elevated LDL and triglycerides (TG) on the lipid panel done 3/2/18. These labs were not addressed in an individual with increased CV risk.

d. When prescribers agreed to recommendations for the individuals reviewed, documentation was generally presented to show they implemented them. The exception was for Individual #115 (i.e., the Pharmacist identified Robitussin did not have a stop date, but the PCP did not respond).

e. As noted with regard to Outcome #1, the Monitoring Team is working with State Office on a solution to a problem with the production of documents related to Pharmacy's review of new orders. Until it is resolved and the Monitoring Team is able to identify the full scope of new medications requiring interventions, this indicator is not being rated.

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.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
d.	Individual has made progress on his/her dental goal(s)/objective(s); and	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments: a. and b. The Monitoring Team reviewed nine individuals with medium or high dental risk ratings. None had clinically relevant, achievable, and measurable goals/objectives related to dental.

The Monitoring Team will be working with State Office on this issue so that State Office can provide more guidance to the Centers. A good way to think about it, though, is: "what would the dentist tell the individual he/she or staff should work on between now and the next visit?" For different individuals, the causes of their dental problems are different, and so the solution or goal should be tailored to the problem. For example, should an individual reduce the amounts of sugary snacks he/she consumes, should an individual brush his/her teeth twice a day for two minutes instead of once a day, should a goal revolve around the individual tolerating tooth brushing for 30 seconds leading up to an eventual two minutes? These are the type of questions IDTs should be asking themselves when deciding upon a goal.

c. through e. In addition to the goals/objectives not being clinically relevant, achievable, and measurable, integrated progress reports on existing goals 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. 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	187	170	32	118	155	58	115	177	107
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									
Comments: Individual #115 was edentulous. c. As indicated in the dental audit tool, this indicator will only be scored for individuals residing at Centers at which inter-rater reliability with the State Office definitions of good/fair/poor oral hygiene has been established/confirmed. If inter-rater reliability has not been established, it will be marked "N/R." At the time of the review, State Office had not yet developed a process to ensure inter-rater reliability with the Centers.											

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: Based on the Monitoring Team's review of dental documentation for review of other indicators, a number of individuals had not had tooth-brushing instruction twice a year. As a result, Indicator b will move back to active monitoring. A number of individuals reviewed had not had needed dental treatment. This has been a consistent concern at El Paso SSLC, and needs to be corrected.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
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.	25% 2/8	0/1	0/1	0/1	1/1	0/1	0/1	N/A	1/1	0/1
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, this indicator moved to the category requiring less oversight. However, based on the Monitoring Team's review of dental documentation for review of other indicators, a number of individuals									

		had not had tooth-brushing instruction twice a year. As a result, Indicator b will move back to active monitoring.									
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines, unless a justification has been provided for not conducting x-rays.	25% 2/8	1/1	0/1	0/1	0/1	0/1	0/1		1/1	0/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	25% 2/8	0/1	0/1	0/1	0/1	0/1	1/1		1/1	0/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	33% 1/3	1/1	N/A	0/1	N/A	N/A	0/1		N/A	N/A
f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments: a. through f. Individual #115 was edentulous.

Only three of eight individuals or their staff had tooth brushing instruction twice per year, so Indicator b will return to active monitoring.

A number of individuals reviewed had not had needed dental treatment. This has been a consistent concern at El Paso SSLC, and needs to be corrected.

Outcome 7 – Individuals receive timely, complete emergency dental care.

Summary: Based on the one dental emergency reviewed, the dentist provided the individual with timely dental assessment and care. If the Center sustains this performance, at the time of the next review, Indicators a and b might move to less oversight. Pain assessment and management, and documentation of it are areas on which the Center should focus.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	100% 1/1	N/A	N/A	N/A	1/1	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.	0% 0/1				0/1					

Comments: a. through c. On 7/13/18, nursing staff documented dry blood in Individual #118's mouth. The PCP saw her, and noted she was tachycardic. The PCP ordered labs and referred her to the dentist.

On 7/13/18, the dentist saw her for a limited exam. The dentist noted redness and signs of cheek biting on the right side of her inner cheek, as well as slight extra-oral swelling to the right cheek. The plan was to follow-up in one week. On 7/19/18, the dentist saw her again, and reported the lesion had healed.

Neither the PCP nor the dentist conducted and/or documented a pain assessment.

Outcome 8 – Individuals who would benefit from suction tooth brushing have plans developed and implemented to meet their needs.											
Summary: These indicators will continue in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	If individual would benefit from suction tooth brushing, her/his ISP includes a measurable plan/strategy for the implementation of suction tooth brushing.	100% 4/4	N/A	N/A	1/1	1/1	1/1	N/A	1/1	N/A	N/A
b.	The individual is provided with suction tooth brushing according to the schedule in the ISP/IHCP.	75% 3/4			0/1	1/1	1/1		1/1		
c.	If individual receives suction tooth brushing, monitoring occurs periodically to ensure quality of the technique.	0% 0/4			0/1	0/1	0/1		0/1		
d.	At least monthly, the individual's ISP monthly review includes specific data reflective of the measurable goal/objective related to suction tooth brushing.	0% 0/4			0/1	0/1	0/1		0/1		

Comments: a. It was good to see that for the four applicable individuals, IDTs included suction tooth brushing strategies/plans in their ISPs/IHCPs.

c. Although it appeared that Dental Department staff conducted some monitoring of staff's implementation of suction tooth brushing for quality, as well as safety, ISP action plans did not define the frequency expected to meet the individuals' needs. As a result, the Monitoring Team could not determine whether or not the frequency was sufficient.

Since the inception of the Dental Audit Tool, in January 2015, the interpretive guidelines for this indicator have read: "Frequency of monitoring should be identified in the individual's ISP/IHCP, and should reflect the clinical intensity necessary to reduce the individual's risk to the extent possible." However, at the time of the last review, the Monitoring Team might have incorrectly scored this indicator (i.e., the Center scored 100% during Round 13). Moving forward, IDTs should ensure that individuals with suction tooth brushing have IHCPs that define the frequency of monitoring and it is implemented according to the schedule.

d. Often, QIDP reports did not include specific data to summarize the frequency of sessions completed in comparison with the number anticipated (e.g., 60 out of 62 sessions). Additionally, a second data subset should provide data on the number of such events during which the individual completed two minutes of suction tooth brushing (e.g., of the 60 completed sessions, 12 sessions completed two minutes of suction tooth brushing).

Outcome 9 – Individuals who need them have dentures.											
Summary: If the Center sustains it performance with regard to the dentist making clinically justified recommendations related to dentures for individuals with missing teeth, after the next review, Indicator a might move to the category of less oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments: a. For the individuals reviewed with missing teeth, the Dental Department provided clinical justification for not recommending dentures.											

Nursing

Outcome 1 – Individuals displaying signs/symptoms of acute illness and/or an acute occurrence (e.g., pica event, dental emergency, adverse drug reaction, decubitus pressure ulcer) have nursing assessments (physical assessments) performed, plans of care developed, and plans implemented, and acute issues are resolved.											
Summary: These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
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	0%									

	post-hospitalization assessments.										
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. In the months prior to the review, State Office provided training to all of the Centers on the development of acute care plans. During this round of reviews, the Monitoring Team is working with State Office on ensuring Centers provide the correct documentation for review of acute care plans. Given the timing of the El Paso SSLC review, the Center was in the initial stages of implementing the revised acute care plan template/process. It was decided that the Monitoring Team would not search for needed acute care plans that might not exist throughout the preceding six months. However, as a result of the ongoing systems issue since the implementation of IRIS, these indicators do not meet criteria. Center staff should continue to work with State Office to correct the issues. By the time of the next review, the Monitoring Team plans to conduct a full review of acute care plans.

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 clinically relevant outcomes related to at-risk conditions requiring nursing interventions. These indicators will remain in active oversight.

			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual has a specific goal/objective that is clinically relevant and achievable to measure the efficacy of interventions.	6% 1/18	1/2	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	0/2	0/2	0/2	2/2	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: For nine individuals, the Monitoring Team reviewed a total of 18 IHCPs addressing specific risk areas (i.e., Individual #187 – seizures, and choking; Individual #170 – constipation/bowel obstruction, and infections; Individual #32 – GI problems, and cardiac problems; Individual #118 – dental, and constipation/bowel obstruction; Individual #155 – aspiration, and falls; Individual #58 – infections, and GI problems; Individual #115 – respiratory compromise, and circulatory; Individual #177 – weight, and diabetes; and Individual #107 – GI problems, and skin integrity).

a. and b. The IHCP that included a clinically relevant, and achievable, but not measurable goal/objective was for: Individual #187 – choking (i.e., alternating solids and liquids).

Although the following goals/objectives were measurable, because they were not clinically relevant, the related data could not be used to measure the individual's progress or lack thereof: Individual #177 – weight, and diabetes.

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: Nurses often did not include comprehensive interventions in IHCPs to address individuals' at-risk conditions, and even for those included in the IHCPs, documentation often was not present to show nurses implemented them. In addition, often IDTs did not collect and analyze information, and develop and implement plans to address the underlying etiology(ies) of individuals' risks. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
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	N/A	0/2	0/1	0/1	0/2	N/A	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).	6% 1/18	0/2	0/2	0/2	0/2	0/2	0/2	1/2	0/2	0/2

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

a. and c. As noted above, for individuals with medium and high mental health and physical health risks, IHCPs did not meet their needs for nursing supports. However, the Monitoring Team reviewed the nursing supports that were included to determine whether or not they were implemented. For the individuals reviewed, evidence was generally not provided to support that the nursing components of individuals' IHCPs were fully implemented beginning within 14 days of finalization or sooner, or that nursing interventions were implemented thoroughly. Often, some, but not all interventions had documentation to support implementation. In addition, many of the action steps for nursing were not measurable. For Individual #115, nurses did document vital signs as the IHCP required.

b. The following provide some examples of IDTs' responses to the need to address individuals' risks:

- On 4/28/18, at 3:30 p.m., a nurse documented that staff reported Individual #170 was having a large emesis. The nurse noted the individual had not had a bowel movement in 120 hours (i.e., five days). From 4/28/18 to 4/29/18, he was hospitalized for a bowel obstruction secondary to rectal fecal impaction. An ISPA, dated 5/8/18, documented an IDT meeting for the purposes of a psychiatric clinic. During this meeting, the RNCM mentioned his hospitalization and bowel obstruction. However, the IDT did not take this opportunity to review his IRRF and IHCP, or develop and implement interventions/preventive measures, including a bowel management plan that would meet the needs of the individual. Based on the documentation submitted, the IDT did not hold a specific Change of Status (COS) ISPA meeting, or revise the IRRF and IHCP.
- On 2/1/18, Individual #170 was hospitalized for left leg cellulitis. The PCP's note, dated 2/1/18, at 9:19 a.m., stated: "Cellulitis of left leg: given the rapid spread and bullae formation, a toxin producing bacteria is most likely the cause such as Group B streptococcus." On 2/8/18, the individual returned to the Center. On 2/9/18, the IDT held a post-hospital ISPA meeting. The ISPA noted the team agreed to a high-risk rating for infections due to the individual's hospitalizations. A COS IRRF was not found. The IDT did not seem to grasp that his self-injurious behavior (SIB), coupled with his non-compliance with hygiene tasks increased his risk for infections, skin integrity issues, and cellulitis. As a result, the IDT did not put a reasonable plan in place to address these issues.
- On 4/4/18, while in the hospital with diagnosis of failure to thrive, Individual #32 had a G-tube placed. An ISPA, dated 4/5/18, was limited to discussion about allegations, and pre-treatment sedation. The next ISPA was for the purpose of follow-up on walking and wheelchair use. Based on the documentation submitted, the IDT did not hold an ISPA meeting to address his post-hospitalization needs related to his cellulitis, and the G-tube placement.
- On 4/3/18, Individual #118's IDT held an ISPA meeting to discuss her recent hospitalization, programming, risk, interventions, supports, and level of supervision (LOS). Based on the signatures, the PCP did not attend the meeting. The ISPA included the following statement: "revise hydration plan and get medical more involved in monitoring." The IDT documented no suggestions/discussions/recommendations for interventions to minimize her constipation. The IRRF folder and IHCP folder did not document action steps from the IDT's discussions. The next ISPA, dated 5/14/18, indicated the IDT met for the purpose of an update on weight monitoring.
- On 4/2/18, Individual #155's IDT held an ISPA meeting for the purpose of a post-hospitalization review, an initial root cause analysis, referral to the PNMT, and follow-up discussion of falls from an ISPA, dated 3/22/18. The IDT documented discussion related to her hospitalization diagnoses; in-patient treatment and post-hospitalization needs; post-hospitalization assessment regarding her current seating supports, with a recommendation to support reflux precautions and decrease her risk for aspiration; and discontinuation of the use of the recliner. Plans included an alternative chair. The record indicated that the IDT and PNMT reviewed the individual's goals, found she was not meeting them, and indicated revision was indicated, based on the root cause analysis and PNMT review. The IDT indicated they would do this as part of the upcoming ISP meeting, which did not occur until 4/19/18. The IDT identified some immediate actions for Habilitation Therapies, such as "Modify PNMP for upright position 45 minutes vs 30 min." Nursing action steps were listed with an implementation date of 5/12/18. For nursing, the IDT identified no immediate additions to the previously stated actions steps.
- Individual #177 had a number of blood glucose finger sticks readings that were above 200 or were recorded as "High." Over time, the individual had medication changes, including the addition of insulin. Apparently, he was fitted with a continuous blood glucose monitoring device (a specific date could not be found in the records). An IPN noted that on 3/28/18, he self-reported removing the device. Based on the documents submitted, the IDT did not hold ISPA meetings to address his chronic health condition of his diabetes or how he was participating in the management of the disease process.

- Although on 9/14/18, Individual #107's IDT met to complete a monthly review, it did not appear the IDT discussed his ear laceration/abscess with positive cultures.

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

Summary: For at least the two 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) nurses following individuals' PNMPs while administering medications. However, given the importance of these indicators to individuals' health and safety, these indicators will continue in active oversight 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: 187	170	32	118	155	58	115	177	107
a.	Individual receives prescribed medications in accordance with applicable standards of care.	N/R	N/R			N/R			N/R		N/R
b.	Medications that are not administered or the individual does not accept are explained.	N/R									
c.	The individual receives medications in accordance with the nine rights (right individual, right medication, right dose, right route, right time, right reason, right medium/texture, right form, and right documentation).	100% 4/4		1/1	1/1		N/A	1/1		1/1	
d.	In order to ensure nurses administer medications safely:										
	i. For individuals at high risk for respiratory issues and/or aspiration pneumonia, at a frequency consistent with his/her signs and symptoms and level of risk, which the IHCP or acute care plan should define, the nurse documents an assessment of respiratory status that includes lung sounds in IView or the IPNs.	100% 3/3	N/A	N/A	1/1	N/A	1/1	N/A	1/1	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	100% 2/2	N/A	N/A	1/1	N/A	1/1	N/A	N/A	N/A	N/A

	enteral feeding tube, then the nurse assesses lung sounds before and after medication administration, which the IHCP or acute care plan should define.										
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.	75% 3/4		1/1	1/1		1/1	0/1		N/A	
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	100% 5/5		1/1	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 followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	N/R									
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/R									

Comments: Due to problems related to the production of documentation from IRIS in relation to medication administration, the Monitoring Team could not rate many of these indicators. The Monitoring Team conducted observations of five individuals, including Individual #170, Individual #32, Individual #155, Individual #58, and Individual #177. Individual #115 was in the hospital, and the Monitoring Team was not able to observe Individual #187, Individual #118, or Individual #107.

c. It was positive that for the individuals the Monitoring Team member observed during medication passes, nursing staff followed the nine rights of medication administration. When the nurse was preparing Individual #155's medications for administration, the residual in her G-tube was above the set threshold, so medications were held. As a result, this indicator could not be scored.

d. It was positive that for the individuals at high risk for respiratory compromise and/or with diagnoses of aspiration pneumonia/pneumonia within the last year, their ISPs defined and nurses performed respiratory assessments to assist in ensuring the individuals' safety during medication administration.

f. During the onsite observations, most medication nurses used the individuals' PNMPs and checked the positions of the individuals prior to medication administration. However, for Individual #58, the Nurse Educator accompanying the Monitoring Team had to prompt the medication nurse to review the PNMP and address the individual's positioning prior to the administration of medication.

g. For the individuals observed, nursing staff followed infection control practices, which was good to see.

Physical and Nutritional Management

Outcome 1 – Individuals' at-risk conditions are minimized.

Summary: It was good to see that IDTs referred individuals that should have been referred to the PNMT, or the PNMT made self-referrals. Overall, though, IDTs and/or the PNMT did not have a way to measure outcomes related to individuals' physical and nutritional management (PNM) at-risk conditions. These indicators will remain in active oversight.

#	Indicator	Overall Score	Individuals: 187	170	32	118	155	58	115	177	107
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;	25% 3/12	1/2	0/1	0/1	0/1	0/1	1/2	1/1	0/2	0/1
	ii. Individual has a measurable goal/objective, including timeframes for completion;	17% 2/12	0/2	0/1	1/1	0/1	0/1	0/2	0/1	1/2	0/1
	iii. Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/2	0/1	N/A	0/1
	iv. Individual has made progress on his/her goal/objective; and	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/2	0/1	N/A	0/1
	v. When there is a lack of progress, the IDT takes necessary action.	0% 0/10	0/2	0/1	0/1	0/1	0/1	0/2	0/1	N/A	0/1
b.	Individuals are referred to the PNMT as appropriate, and show progress on their individual goals/objectives or teams have taken reasonable action to effectuate progress:										
	i. If the individual has PNM issues, the individual is referred to or reviewed by the PNMT, as appropriate;	100% 6/6	N/A	1/1	1/1	1/1	1/1	N/A	1/1	N/A	1/1
	ii. Individual has a specific goal/objective that is clinically	0%		0/1	0/1	0/1	0/1		0/1		0/1

		relevant and achievable to measure the efficacy of interventions;	0/6									
	iii.	Individual has a measurable goal/objective, including timeframes for completion;	0% 0/6		0/1	0/1	0/1	0/1		0/1		0/1
	iv.	Integrated ISP progress reports include specific data reflective of the measurable goal/objective;	0% 0/6		0/1	0/1	0/1	0/1		0/1		0/1
	v.	Individual has made progress on his/her goal/objective; and	0% 0/6		0/1	0/1	0/1	0/1		0/1		0/1
	vi.	When there is a lack of progress, the IDT takes necessary action.	0% 0/6		0/1	0/1	0/1	0/1		0/1		0/1

Comments: The Monitoring Team reviewed 12 goals/objectives related to PNM issues that nine individuals' IDTs were responsible for developing. These included goals/objectives related to: Individual #187 - falls, and choking; Individual #170 – aspiration; Individual #32 – falls; Individual #118 – fractures; Individual #155 - falls; Individual #58 – falls, and aspiration; Individual #115 – falls; Individual #177 – weight, and falls; and Individual #107 - fractures.

a.i. and a.ii. The IHCPs that included clinically relevant, and achievable goals/objectives were for: Individual #187 – choking (i.e., alternating solids and liquids); Individual #58 – aspiration; (i.e., slow eating and drinking pace); and Individual #115 – falls (i.e., slowing walking pace).

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 #32 – falls, and Individual #177 – weight.

b.i. The Monitoring Team reviewed six 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 for: Individual #170 – constipation/bowel obstruction, Individual #32 – weight, Individual #118 – weight, Individual #155 – aspiration, Individual #115 – aspiration, and Individual #107 – constipation/bowel obstruction.

It was good to see that IDTs referred individuals that should have been referred to the PNMT, or the PNMT made self-referrals.

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.

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	187	170	32	118	155	58	115	177	107
a.	The individual's ISP provides evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provide an explanation for any delays and a plan for completing the action steps.	0% 0/18	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 increased or there was a change in status, there is evidence the team took immediate action.	33% 3/9	N/A	0/2	1/1	0/1	1/1	N/A	0/1	1/2	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% 0/1	N/A	0/1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Comments: a. As noted above, none of IHCPs reviewed included all of the necessary PNM action steps to meet individuals' needs. In addition, documentation generally was not found to confirm the implementation of the PNM action steps that were included.

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

- For a few months, Individual #70 had issues with significant constipation. On 4/28/18, he had not had a bowel movement in 120 hours (i.e., five days), and was sent to the ED. A CT scan of the abdomen was completed and showed a large bowel obstruction secondary to a rectal fecal impaction. After having multiple bowel movements in the ED, the individual was discharged, and returned to the Center

  According to the PCP, the individual did not have good stooling habits at home, and the PCP referred this issue to the IDT for review. On 5/1/18, the PCP reassessed the individual. The plan was to encourage a high-fiber diet and fluids and consult Behavioral Health Services (BHS) regarding abnormal toileting habits. The PCP prescribed Glycerin suppositories, and nurses were to administer them, if the individual had no BM in 48 hours.

  Per the PNMT review, dated 5/2/18, the PNMT considered the root cause of the bowel obstructions to be "the tendency to avoid using the restroom when he experiences the urge to defecate resulting in fecal impaction." This did not address the true root cause, because the PNMT should have attempted to continue to ask "why?" (e.g., why did he avoid using the restroom?). BHS was to consider strategies to promote use of the restroom.

  On 5/8/18, the IDT met, but put no actual plan in place. They did not meet again until 5/24/18, when a plan was presented in general, but the IDT did not establish clear steps or monitoring. At the time of the onsite review in October 2018, the plan was still pending BTC approval and presentation to the LAR.

  It appeared that the IDT established a toileting schedule that was linked to showering and a social story to guide these activities. The ISPA, dated 5/16/18, stated that the IDT would meet on 6/22/18, to discuss the toileting plan, but no evidence

of this was found in the documents submitted. On 6/24/18, the IDT held the next ISPA meeting. A toileting schedule appeared to already be in place at that time, but specific steps, strategies, and monitoring were not outlined in the ISPA. Staff anecdotally reported that this was effective, but this opinion was not based on evidence (i.e., data collection and analysis).

- For Individual #115, since January 2018, the PNMT conducted an assessment or review for each episode of aspiration pneumonia/pneumonia. The IDT held ISPA meetings to discuss the assessments/reviews, and the PNMT recommendations. However, it did not appear that the IDT updated the IHCP to sufficiently address the individual's needs. In August, nursing staff developed an acute care plan to address a pneumonia event, but again, the IDT did not revise or update the IHCP to address his needs over the long-term.
- Individual #177's IDT addressed diet and intake to some degree, and he lost some weight. However, his IDT did not develop an exercise program, or tie his weight issues to his pain from degenerative joint disease and develop a plan to accommodate this concern.
- One of the PNMT review findings for Individual #107 was that he was observed lying flat on his back in bed during personal care activities. Staff underwent additional in-service training with an angle finder for the bed and wheelchair. However, these were not identified in the IHCP at all, and the IDT did not update the IHCP.

c. The PNMT conducted a review with regard to Individual #170's constipation/bowel obstruction. The PNMT only stated that the PCP should consider magnesium citrate if the individual did not have a bowel movement in 96 hours and the IDT should discuss strategies for toileting. As discussed in further detail above, on 5/8/18, the IDT met regarding this issue, but did not put an actual plan in place.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked, and are implemented thoroughly and accurately.			
Summary: Based on observations, individuals generally were positioned correctly, and staff completed transfers correctly. However, numerous issues were noted with staff's implementation of Dining Plans. More specifically, errors with Dining Plan implementation were noted in 48% of the 29 mealtime observations. Many of the errors noted placed individuals at risk of choking or aspiration. Implementation of PNMPs is non-negotiable. The Center, including Habilitation Therapies as well as Residential and Day Program/Vocational staff, should determine the issues preventing staff from implementing PNMPs, particularly Dining Plans, correctly (e.g., competence, accountability, etc.), and address them. These indicators will continue in active oversight.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	67% 31/46	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic	Not rated	

	rationale/reason for the PNMP.	
	Comments: a. The Monitoring Team conducted 46 observations of the implementation of PNMPs. Based on these observations, individuals were positioned correctly during 12 out of 13 observations (92%). Staff followed individuals' dining plans during 15 out of 29 mealtime observations (52%). Staff completed transfers correctly during four out of four observations (100%).	

Individuals that Are Enterally Nourished

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: This indicator will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to an individual's progress along the continuum to oral intake are implemented.	0% 0/3	N/A	N/A	0/1	N/A	0/1	N/A	0/1	N/A	N/A
	Comments: a. For Individual #155, the SLP made one note, dated 8/1/18, documenting initiation of therapy, and one note, dated 8/2/18, in which the SLP reported that the individual lowered her head and closed her eyes. The SLP stated she would attempt to see Individual #155 later that week. However, the notes provided no further evidence of any intervention from then through 8/30/18, which was the document cut-off date. The SLP provided no justification as to why she did not make further attempts to provide therapy.										

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: Most individuals reviewed did not have clinically relevant, and/or measurable goals/objectives to address their needs for formal OT/PT services. In addition, QIDP interim reviews often did not include data related to existing goals/objectives. As a result, IDTs did not have information in an integrated format related to individuals' progress or lack thereof. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	17% 1/6	0/1	N/A	N/A	0/1	N/A	0/1	1/1	0/1	0/1
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.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/5	0/1			0/1		0/1	N/A	0/1	0/1
d.	Individual has made progress on his/her OT/PT goal.	0% 0/5	0/1			0/1		0/1	N/A	0/1	0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/5	0/1			0/1		0/1	N/A	0/1	0/1

Comments: a. and b. Individual #170, Individual #32, and Individual #155 did not have a need for formal OT/PT supports.

Individual #118's gentle stretching goal/objective, and Individual #58's neck extension goal/objective for direct therapy were not included in their ISPs or integrated through ISPAs.

The goal/objective that was clinically relevant and achievable, but not measurable was for Individual #115 (i.e., ambulating 50 feet), because it did not provide criteria for achievement.

c. Overall, in addition to a lack of clinically relevant and achievable goals/objectives, progress reports, including data and analysis of the data, were generally not available to IDTs in an integrated format and/or in a timely manner. As a result, it was difficult to determine whether or not individuals were making progress on their goals/objectives, or when progress was not occurring, that the IDTs took necessary action. 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: For the individuals reviewed, evidence was not found in ISP integrated reviews to show that OT/PT supports were implemented. These indicators will continue in active oversight.

Individuals:

#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	0% 0/4	0/1	N/A	N/A	0/1	N/A	0/1	N/A	N/A	0/1
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	33% 1/3	N/A	N/A	N/A	0/1	N/A	0/1	N/A	N/A	1/1

Comments: a. Overall, there was a lack of evidence in integrated ISP reviews that supports were implemented. OTs and PTs should work with QIDPs to ensure data are included and analyzed in ISP integrated reviews.

b. No ISPA was found documenting discussion of Individual #118's discharge from PT services.

Individual #58's IDT did not provide a clinical justification for discharging her from direct OT services, as opposed to modifying the plan to increase her cooperation.

Outcome 5 – Individuals have assistive/adaptive equipment that meets their needs.											
Summary: It was positive that most individuals observed had equipment that fit them properly. Given the importance of the proper fit of adaptive equipment to the health and safety of individuals, Indicator c will remain in active oversight. During future reviews, it will also be important for the Center to show that it has its own quality assurance mechanisms in place for these indicators. [**Note:** due to the number of individuals reviewed for these indicators, scores for each indicator continue below, but the totals are listed under "overall score."]			Individuals:								
#	Indicator	Overall Score	169	187	118	127	70	58	4	6	128
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance with these indicators, they 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.	84% 16/19	0/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
		Individuals:									
#	Indicator		28	103	155	129	102	16	96	60	9
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		0/1	1/1	0/1	1/1	2/2	1/1	1/1	1/1	1/1
Comments: c. The Monitoring Team conducted observations of 19 pieces of adaptive equipment. Based on observation of Individual #169, and Individual #155 in their wheelchairs, the outcome was that they were not positioned correctly. It is the Center's responsibility to determine whether or not these issues were due to the equipment, or staff not positioning individuals correctly, or other factors. Individual #28 was not positioned forward enough on the wedge so her shoulders were not positioned or supported properly. It was unclear whether or not this was due to proper fit.											

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, five indicators were moved to, or were already in, the category of requiring less oversight. For this review, no other indicators will be moved to this category, however, one indicator, in communication, will be returned to 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.

It was good to see that DSPs were knowledgeable about many of the support needs of individuals and engaged in positive respectful interactions.

For the 10 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 for almost all of the goals (i.e., indicator 3). For the one goal that did meet criteria with indicators 1-3, data indicated that the individual was making progress, however, his latest QIDP monthly review noted that the goal was discontinued because he had met his goal. The IDT did not recommend a replacement goal.

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

Based on the Monitoring Team's observations of the use of AAC devices, a number of individuals (36%) who should have had AAC devices readily available for their use did not. As a result, the related indicator will return to active oversight. In addition to ensuring individuals have ready access to their AAC devices, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner.

Most SAPs contained many, if not most, of the standard required components. One SAP contained all of them. It was positive to see the initiation of SAP integrity/data reliability assessments.

The continuation, discontinuation, or modification of SAPs was not consistently data based. El Paso SSLC could not yet show that any SAPs were making progress. When not making progress, actions were taken for about one-third of the SAPs.

Engagement was generally very good for the individuals in the review group and for all individuals at the Center.

ISPs

Outcome 2 – All individuals are making progress and/or meeting their personal goals; actions are taken based upon the status and performance.											
Summary: Given that all but one of the goals did not meet criterion with all three ISP indicators 1-3 (individualized, measurable, and data available), the indicators of this outcome also did not meet criteria. The one goal that met criteria with these indicators was met, which was good to see (though an updated or new goal was not created, indicator 5). These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	170	69	187	155	32			
4	The individual met, or is making progress towards achieving his/her overall personal goals.	0% 0/6	0/6	1/6	0/6	0/6	0/6	0/6			
5	If personal goals were met, the IDT updated or made new personal goals.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
6	If the individual was not making progress, activity and/or revisions were made.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			
7	Activity and/or revisions to supports were implemented.	0% 0/6	0/6	0/6	0/6	0/6	0/6	0/6			

Comments:
4-7. For personal goals that did not meet criterion as described above, there was no basis for assessing progress in these areas.

For the 10 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 for almost all of the goals (i.e., indicator 3). For the one goal that did meet criteria with indicators 1-3, data indicated that the individual was making progress, however, his latest QIDP monthly review noted that the goal was discontinued because he had met his goal. The IDT did not recommend a replacement goal.

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

Outcome 8 – ISPs are implemented correctly and as often as required.											
Summary: It was good to see that DSPs were knowledgeable about many of the support needs of individuals and engaged in positive respectful interactions. When ISPs are fully implemented, the Monitoring Team will be able to determine if DSPs were able to competently implement the plans. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall	135	170	69	187	155	32			

		Score									
39	Staff exhibited a level of competence to ensure implementation of the ISP.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
40	Action steps in the ISP were consistently implemented.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

Comments:
39. Direct support professional staff interviewed and observed throughout the week were knowledgeable about individual's preferences and support needs and very respectful and supportive to each individual in their interactions.

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. As noted throughout this section of the report, ISPs often included SOs that did not have specific implementation methodologies and this contributed to the lack of implementation.

40. Action steps were not regularly and correctly implemented for all goals and/or action plans, as noted throughout this report.

Going forward, IDTs need ensure all staff have instructions for carrying out action plans and then 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: El Paso SSLC could not yet show that any SAPs were making progress. When not making progress, actions were taken for about one-third of the SAPs. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
6	The individual is progressing on his/her SAPs.	0% 0/18	0/3	N/A	0/2	0/3	0/2	0/3	None	0/3	0/2
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	None	N/A	N/A
8	If the individual was not making progress, actions were taken.	33% 3/9	0/1	N/A	N/A	2/2	N/A	0/2	None	1/3	0/1
9	(No longer scored)										

Comments:
6. No individual had reliable data indicating he or she was making progress. Individual #192's sign in and out of vocational services and identify pictures of the months SAPs were scored NA because although they did have reliable data (see indicator 5), they had

insufficient data to determine progress.

Some SAPs appeared to be progressing (e.g., Individual #187's turn on her TV 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 #69's connect his gaming system SAP). Finally, some of the SAP data indicated no progress (e.g., Individual #198's ID safe and unsafe pictures SAP).

7. No SAPs were indicated to have been met.

8. Three of the nine SAPs judged as not progressing had evidence that action was taken to address the lack of progress. For example, Individual #108's use her communication SAP was not progressing and the SAP progress note indicated that her staff would be retrained on the implementation and scoring of this SAP. On the other hand, for six other SAPs that were also not progressing, however, no actions were taken (e.g., Individual #135's call his parents SAP).

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

Summary: Most SAPs contained many, if not most, of the standard required components. One SAP contained all of them. Progress was seen since the last review. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
13	The individual's SAPs are complete.	5% 1/20	0/3 12/27	0/2 11/18	0/2 11/18	0/3 16/29	0/2 12/19	1/3 22/28	None	0/3 18/28	0/2 6/18

Comments:
13. In order to be scored as complete, a skill acquisition plan (SAP) must contain 10 components necessary for optimal learning.

Because all 10 components are required for the SAP to be judged to be complete, the Monitor has provided a second calculation in the individual boxes above that shows the total number of components that were present for all of the SAPs chosen/available for review.

One SAP, Individual #187's turn on her TV SAP was judged to be complete.

Even so, many of the SAPs contained the majority of these components. For example, about 80% of the SAPs had a plan that included:

- a task analysis (when appropriate)
- teaching schedule
- specific consequences for incorrect responses, and documentation methodology
- documentation methodology

Regarding common missing components:

- A common missing component was the absence of clear maintenance and/or generalization plans (e.g., Individual #181's

identifying safe and unsafe situations). Maintenance plans should articulate how El Paso SSLC will ensure that the individual will continue to utilize the skill after he or she masters it (e.g., the individual will be required to independently brush their teeth each morning and evening). Generalization plans identify how El Paso SSLC will ensure that the new skill will be applied to new areas (e.g., the individual will independently brush her teeth on home visits).

- The use of reinforcement was not consistently individualized. The majority of SAPs specified the use of praise following the correct implementation of the SAP (e.g., Individual #187's press the call button). Praise maybe a potent reinforcer for some individuals, but for many individuals it is not particularly reinforcing. Ensuring individualized reinforcement (e.g., immediate access to a preferred activity contingent on correct responding) of correct responding is critical to teaching new skills.
- Clear SAP training instructions were often missing. For some SAPs, it was not clear if the skill consisted of one step or multiple steps (e.g., Individual #108's turn on the radio SAP). For other multiple-step SAPs, the training instructions did not clearly indicate if training should occur on one step or multiple steps at each training session (e.g., Individual #198's put in his hearing aid SAP). The use of the SAP training sheet often contributed to confusing staff instructions. The skill steps section of the SAP should include the task analysis (the behaviors the individual engages in), while the training instructions section should include the staff's behavior to teach the skill steps. Many of the SAPs, however, included individual and staff behaviors in the skill steps section of the SAP training sheet, resulting in confusing staff instructions.
- Some SAPs did not include operational definitions of the task. For example, Individual #135's save money SAP did not specify how he should ensure his money is safe (e.g., put it in his dresser draw, in a lock box, etc.).

Outcome 5- SAPs are implemented with integrity.

Summary: Although both indicators performed far below criteria, some progress and improvement were seen, which was encouraging. These two indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
14	SAPs are implemented as written.	33% 1/3	0/1	N/A	Attempted	N/A	Attempted	0/1	No SAPs	1/1	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.	25% 5/20	1/3	2/2	0/2	0/3	0/2	1/3	None	0/3	1/2

Comments:

14. The Monitoring Team attempted to observe the implementation of several SAPs. Some, however, could not be observed because of behavioral issues (e.g., Individual #170's play his game SAP), or the individual was not available/refused to participate in the SAP (e.g., Individual #108's turn on her radio SAP). Of the three SAPs observed, Individual #198's identify pictures of safe and unsafe scenarios SAP was implemented as written and scored correctly. Individual #135's clean his shaver SAP was implemented as written, but the DSP did not identify the correct prompt level. Individual #187's turn on her TV SAP was not implemented as written.

15. El Paso SSLC established that each SAP would be monitored at least every six months and that IOA and integrity would be at least 80%. IOA and treatment integrity goals were achieved for five SAPs (see indicator 5).

Outcome 6 - SAP data are reviewed monthly, and data are graphed.												
Summary: Both indicators improved from 0% scores at the last review. Graph presence sets the occasion for monthly reviews to occur and for them to be meaningful. Both indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
16	There is evidence that SAPs are reviewed monthly.	11% 2/19	1/3	0/2	0/2	0/3	1/1	0/3	None	0/3	0/2
17	SAP outcomes are graphed.	100% 16/16	2/2	1/1	2/2	3/3	1/1	3/3	None	3/3	1/1

Comments:

16. Individual #69's identify his staff and Individual #135's clean his shaver SAPs did have monthly data reviews. Individual #69's connect his gaming system SAP was not scored because it was not initiated at the time of the QIDP monthly review. Some SAPs were not reviewed in QIDP monthly reports (e.g., Individual #135's call his parents SAP), others did not include SAP data (e.g., Individual #192's sign in and out of vocational services SAP), others were reviewed, but only one month of SAP data were presented, which did not allow data-based decisions concerning the need to continue, discontinue, or modify them (e.g., Individual #170's save money SAP).

17. All of the SAPs with data were graphed. Individual #135's save money, Individual #181's identify pictures of safe and unsafe scenarios, Individual #192's sign in and out of vocational services, and Individual #69's connect his gaming system SAPs did not have data.

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.												
Summary: Center engagement data (indicator 21) and Monitoring Team data (indicator 18) were about the same. Many individuals were engaged during direct observations. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	135	192	170	108	69	187	134	198	181
18	The individual is meaningfully engaged in residential and treatment sites.	62% 5/8	1/1	1/1	0/1	0/1	1/1	0/1	1/1	1/1	N/A
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.	44% 4/9	0/1	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1

Comments:
18. The Monitoring Team directly observed eight of the nine individuals (Individual #181 was not on campus during the onsite review) multiple times in various settings on campus during the onsite week. The Monitoring Team found five (Individual #135, Individual #69, Individual #134, Individual #198, Individual #192) of the eight individuals consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations). Overall, the Monitoring Team continued to be impressed with the level of individual engagement across the campus. The Center had a detailed recreation calendar of events.

19-21. El Paso SSLC conducted monthly engagement measures in all residential and day programming sites. They conducted at least two measures per month, per treatment site. They recently expanded the number of staff who collect monthly engagement data and send those data to the residential coordinators for their review. El Paso SSLC's established engagement goal was individualized across treatment sites. The facility's engagement data indicated that 44% of the residential and day treatment sites of the individuals in the review group achieved their engagement goals.

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

Summary: One individual had a goal and met that goal for community recreational activities. Many individuals participated in community outings. To meet criteria with these indicators, goals for outings and for community teaching/training need to be made (and met). These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 135	192	170	108	69	187	134	198	181
22	For the individual, goal frequencies of community recreational activities are established and achieved.	11% 1/9	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. Individual #108 had a goal of at least one community outing per month, and available documentation indicated that she exceeded that goal each of the last six months. There was evidence that all of individuals, other than Individual #181, participated in community outings, however, there were no established goals for this activity. The facility should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved.

El Paso SSLC did not provide data concerning the implementation of SAPs in the community. SAP training data and a goal for the frequency of SAP training in community should be established for each individual, and the facility needs to demonstrate that the goal was achieved.

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

Dental

Outcome 2 – Individuals with a history of one or more refusals over the last 12 months cooperate with dental care to the extent possible, or when progress is not made, the IDT takes necessary action.											
Summary: 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	187	170	32	118	155	58	115	177	107
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions;	0% 0/3	N/A	0/1	0/1	N/A	N/A	N/A	N/A	N/A	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion;	0% 0/3		0/1	0/1						0/1
c.	Monthly progress reports include specific data reflective of the measurable goal(s)/objective(s);	0% 0/3		0/1	0/1						0/1
d.	Individual has made progress on his/her goal(s)/objective(s) related to dental refusals; and	0% 0/3		0/1	0/1						0/1
e.	When there is a lack of progress, the IDT takes necessary action.	0% 0/3		0/1	0/1						0/1
Comments: a. through d. For the three 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: Since the last review, some improvement occurred with the	Individuals:

measurability of communication goals/objectives the Monitoring Team reviewed Work is still needed to improve the clinical relevance of goals/objectives, and to ensure that individuals have communication goals/objectives to address their needs. It also will be important for SLPs to work with QIDPs to include data and analysis of data on communication goals/objectives in the QIDP integrated reviews. These indicators will remain under active oversight.											
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/13	0/3	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	38% 5/13	2/3	1/2	0/1	2/2	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% 0/13	0/3	0/2	0/1	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% 0/13	0/3	0/2	0/1	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% 0/13	0/3	0/2	0/1	0/2	0/1	0/1	0/1	0/1	0/1
Comments: a. and b. 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 #187 (i.e., asking to have dirty brief changed, and using the call bell, because of the lack of functional application in the way the goals/objectives were written), Individual #170 (i.e., signing hello, more, and shower, because the goal/objective did not identify functional contexts for the skills), and Individual #118 (i.e., choosing radio stations, and clapping to song she likes without a clear mechanism for identifying the individual's choices). c. For the nine 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: To move forward, QIDPs and SLPs should work together to make sure QIDP monthly reviews include data and analysis of data related to the implementation of communication strategies and SAPs. These indicators will remain in active oversight.			Individuals:								
#	Indicator	Overall Score	187	170	32	118	155	58	115	177	107
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are	0% 0/9	0/3	0/2	N/A	0/2	0/1	N/A	0/1	N/A	N/A

	implemented.										
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	N/A									

Comments: a. As indicated in the audit tool, the Monitoring Team reviewed the ISP integrated reviews to determine whether or not the measurable strategies related to communication were implemented. Examples of concerns included:

- QIDP monthly reviews sometimes indicated the strategies/SAPs had not been implemented, but often did not indicate what, if any, action was taken.
- In other instances, the QIDP reviews did not include any data in relation to the identified communication strategies/SAPs.

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: Based on the Monitoring Team's observations of the use of AAC devices, a number of individuals (36%) who should have had AAC devices readily available for their use did not. As a result, Indicator b will return to active oversight. In addition to ensuring individuals have ready access to their AAC devices, SLPs should work with direct support professional staff and their supervisors to increase the prompts provided to individuals to use their AAC devices in a functional manner. These indicators will remain in active monitoring.

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

#	Indicator	Overall Score	Individuals: 85	170	155	25	103	117	129	199	104
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	Due to the Center's sustained performance with this indicator, it moved to the category requiring less oversight. Based on the Monitoring Team's observations of the use of AAC devices, a number of individuals (36%) who should have had AAC devices readily available for their use did not. As a result, Indicator b will return to active oversight.									
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	38% 3/8	1/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	N/A
			Individuals:								
#	Indicator		169								
b.	Individual is noted to be using the device or language-based support		N/A								

	in a functional manner in each observed setting.										
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.	75% 3/4									
Comments: a. and b. Individual #104 and Individual #169 had their AAC devices with them, but at the time of the observations, there was not an opportunity for them to use them functionally or for staff to prompt their use (e.g., AAC device designed for use during mealtime, or at shower time). Based on the Monitoring Team's observations, a number (36%) of individuals who should have had AAC devices readily available for their use did not. As a result, Indicator b will return to active oversight. In addition, it was concerning that when opportunities for using the devices presented themselves, staff often 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. For this review, one additional indicator was moved to this category.

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

El Paso SSLC maintained a strong transition department staff. The APC, transition specialist, and post move monitor were very experienced and knowledgeable about the transition process, community providers, and challenges that they (and individuals, their families, and IDTs) faced in thinking about and moving to the community.

There were many positive observations. Overall, the Monitoring Team commends the transition staff for identifying improvement needs and taking assertive action to address them, which had resulted in progress in several areas. For example, the Center continued to make progress in the development of measurable supports, particularly as a result of several strategies. These included (a) a thorough pre-CLDP review of assessments prior to the CLDP meeting, and (b) to address post-move behavioral needs and issues, bringing in outside resources to educate IDTs about behavioral interventions in the community and doing additional monitoring of providers' understanding of and competence to deliver behavioral supports during overnight visits prior to the CLDP and before transition occurs.

The Center implemented positive practices by involving Center direct support staff in pre-move provider visits in a meaningful way. The Post-Move Monitor continued to be very diligent in her work.

There remained some areas for improvement. The IDTs still needed to ensure they developed comprehensive supports that were also coherent and concise, rather than relying on copying and pasting assessment sections. More is not necessarily better. The IDTs needed to sift carefully through assessments and other documentation to precisely identify what provider staff needed to know and be able to do to appropriately serve each individual.

This lack of precision negatively impacted CLDP pre-move provider training supports that form the basis for ensuring an individual will be well and safely served. For these two CLDPs, these supports typically included extensive detail taken from the various discipline assessments. While it was positive the IDTs endeavored to develop training supports that were comprehensive, it was not clear whether all the information provided within each support represented the required competency criteria.

For both individuals, the pre-move training supports specified written exams and sign-in sheets as the measurable evidence of competence, and the Center had made progress in this area. Still, the exams provided for review frequently did not cover all the material specified in the supports. IDTs needed to consider whether a written quiz was sufficient to demonstrate competence. In some instances, return demonstration might be more likely to ensure provider staff had necessary skills in addition to knowledge.

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 progress; the quality of the CLDP lists of pre and post move supports continued to improve. In all, some of the sub-indicators of indicator 2 were met for one or both individuals. The transition department staff continued to be responsive to comments from the Monitoring Team. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 36	171							
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 transitioned from the Center to the community since the last review and both were included in this review (Individual #171, Individual #36). Both individuals transitioned to community homes operated under the State's HCS program. The Monitoring Team reviewed these transitions and discussed them in detail with the El Paso SSLC Admissions and Placement staff.

1. IDTs must describe supports in clear and measurable terms to ensure that there is a common understanding between the Center and community providers about how individuals' needs and preferences will be addressed. This also provides a benchmark for the Center and community providers to evaluate whether the supports are being carried out as prescribed and to make any needed modifications. At the time of the last review, the Monitoring Team found the Center had made progress, particularly in defining more specific criteria related to pre-move training, including identifying the staff to be trained and how it intended to confirm staff competency. For the present review, the Center continued to make progress in the development of measurable supports, particularly as a result of several strategies.

These included a thorough pre-CLDP review of assessments prior to the CLDP meeting. Transition staff had developed discipline-specific Discharge Assessment Checklists as tools to ensure that the various disciplines had a clear understanding of the expectations for their assessments, and often worked one-on-one with assessors to address any inconsistencies or lack of clarity. As a result, assessments more often provided improved measurable recommendations that could be used to develop supports that were likewise measurable. It was very positive transition staff had implemented these approaches and progress was evident.

Still, IDTs needed to continue to focus on identifying the measurable criteria upon which the Post-Move Monitor (PMM) could accurately judge implementation of each support. Findings for both pre-move and post-move supports for these two CLDPs included, but were not limited to the following:

- Pre-move supports: The respective IDTs developed 47 pre-move supports for Individual #171 and 48 pre-move supports for Individual #36. For both individuals, pre-move supports focused exclusively on a standardized set of categories in which provider training was to be completed prior to transition.
    - These supports typically included extensive detail taken from the various discipline assessments. While it was positive the IDTs endeavored to develop training supports that were comprehensive, it was not clear whether all the information provided within each support represented required competency criteria. The IDTs needed to provide precise and measurable expectations for competency for each pre-move training support.
    - In some instances, some of the detail could have been considered extraneous for the purposes of ensuring provider staff were competent to meet individuals' needs. The IDTs needed to carefully consider what each specific category of provider staff needed to know. For example, a pre-move training support for Individual #36's dental needs required all provider staff to be inserviced on his dental history and status. This included details, such as the date when he last had general anesthesia and who administered it, a set of facts that may have been appropriate for the provider nurse, primary care provider (PCP), and community dentist to know about, but likely not necessary knowledge for direct support staff. At the same time, the support indicated that his behavior was poor, but did not describe what direct support staff should know about these behavioral challenges and how to address them, even though the dental assessment provided a set of strategies for this purpose. For example, these strategies included soft music in the dental clinic, a quiet environment, and to avoid over-prompting, which historically had resulted poor cooperation and combative behavior in the dental clinic.
    - For both individuals, the pre-move training supports specified written exams and sign-in sheets as the measurable evidence of competence. The Center had made progress in this area, as described in more detail under Indicator 14 below. Still, the exams provided for review frequently did not cover all the material specified in the supports. Once the IDTs have defined precise competency criteria in each needed support area, they should also construct corresponding competency test methodologies that allow for accurately measuring the attainment of all the required staff knowledge and skills. This would include ensuring that all required competencies were tested and that an appropriate form of competency testing was considered. As to the latter, IDTs needed to consider whether a written quiz was sufficient to demonstrate competence. In some instances, return demonstration might be more likely to ensure provider staff had necessary skills in addition to knowledge.

- Post-Move: The respective IDTs developed 45 post-move supports for Individual #171 and 43 post-move supports for Individual #36.
    - For both CLDPs, post-move supports largely mirrored the pre-move training supports in terms of content and criteria as described above. Due to the lack of conciseness in the construction, some supports did not make clear what actions or outcomes needed to be measured or how that would be accomplished. For example:
        - For Individual #171, a post-move support for quality of life/workshop included five components. One of these indicated the following: once the provider identified that he could stay on task and was able to carry out a job

in the community, it was further recommended that when starting a new job he would benefit from attending training with a job coach and then slowly reduce supervision through a referral with the Texas Workforce Commission (TWC). The support did not provide any methodology for measuring these various components or include any specific timeframes for achievement.

- It was positive the IDTs referenced various evidence that would be used to measure provider compliance, frequently including the three evidentiary prongs of observations, document review, and staff interviews. At times, the IDTs still needed to ensure these were applied in a manner that would measure the prescribed outcome. For example:
  - For both Individual #171 and Individual #36, post-move supports indicated all staff working with them must be knowledgeable of and familiar with their active medical diagnoses and current plans of care. The prescribed evidence only required the PMM to probe the knowledge of the provider nurse and did not require interviews with the day program and home staff.
  - For both Individual #171 and Individual #36, a post-move support indicated the provider nurse was to ensure continuation of diagnostics and labs as specified by the Center's nursing and medical team and as delineated by lab matrix, until such time the community primary care provider (PCP) made changes. Individual #171's support was measurable because it provided the specific diagnostics and labs, but Individual #36's did not.

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 and detailed effort to describe 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: The CLDPs did not yet develop supports that comprehensively addressed past history, and recent and current behavioral and psychiatric problems. It was positive the Center had identified this an issue that was negatively impacting the success of transitions and had implemented several strategies for improvement. Per interview with transition staff, these included bringing in outside resources to educate IDTs about behavioral interventions in the community and doing additional monitoring of providers' understanding of and competence to deliver behavioral supports during overnight visits prior to the CLDP and before transitions occurred. Other findings for this sub-indicator included:
  - For Individual #171, the IDT did develop extensive post-move supports related to current behavioral needs. This was positive. Still, these supports did not fully address all identified needs. For example, his behavioral health assessment (BHA) indicated he should receive noncontingent reinforcement every 10 minutes, but this was not included in CLDP supports. Per transition staff, the IDT had concluded that a support for providing coupons at the day habilitation program was the more important support and focused on that. This relative assessment of his needs for reinforcement was not represented in the CLDP discussion and so did not provide a clear rationale for focusing on one such need to the exclusion of the other, particularly when both strategies may have enhanced the chances for a successful transition.
  - In addition, per a pre-move ISPA on 6/14/18, Individual #171 had engaged in some unspecified sexually inappropriate behavior. The documentation further noted he was vulnerable to these situations and also had a history initiating these behaviors. The IDT agreed to create a SAP to teach him about dangerous situations, including using a whistle to alert staff if he found himself in those circumstances. It was positive the IDT developed supports for this SAP to be continued in the community, but the supports did not provide any specificity related to sexually inappropriate

behaviors, including what staff should monitor.

- For Individual #36, the Center also developed some behavioral supports. For example, the CLDP included a support for a sensory/quiet room to be maintained for Individual #36's use, based on his assessed needs. This was positive, but some other needs were not comprehensively addressed. The IDT provided a document entitled "How to Work with Individual #36" dated in October 2017. This indicated he had behavioral challenges including self-injurious behavior, described as hitting himself in the head/face or biting his hands; unrelated movements, such as rapid rocking back and forth in his wheelchair; and, loud vocalizations. The aforementioned document provided some strategies for prevention, but did not indicate what actions provider staff should take, such as blocking, when he engaged in self-injurious behavior. The Center also provided a document from April 2016 that indicated he would bite staff and peers and dig his fingers into the arms of staff and peers, but did not provide any strategies for ensuring provider staff knowledge or for prevention and intervention.
- Neither IDT developed pre-or post-move supports that ensured provider staff had specific knowledge of the individuals' significant behavioral and psychiatric histories.
    - For Individual #171, the BHA indicated he had a history of disrobing, but the IDT did not address this in CLDP supports for staff knowledge of the behavior or how it may have been successfully addressed at the Center.
    - Individual #36 did not have BHA that described his behavioral history, so the Monitoring Team found it difficult to make an informed evaluation in this area. As described above, some older documentation indicated he had behavioral needs, but did not address these comprehensively or indicate the current intensity. This was of concern because the IDT had met less than one month before transition to discuss his having had five injuries within 30 days due to self-injurious behavior.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The respective IDTs again developed extensive supports related to safety, medical, healthcare, therapeutic, and risk needs, but still needed to continue to focus on ensuring these were clear and comprehensive. Findings included, but were not limited to the following:
    - For both individuals, the IDTs developed a post-move support that called for 24-hour awake staff available at both the home and the day program to provide supervision and assistance as well as to encourage to perform activities of daily living as independently as possible. It was positive both IDTs addressed supervision needs, but needed to ensure these supports were coherent and comprehensive, so that provider staff could clearly understand the full scope of each individual's requirements. For example:
        - Individual #171's CLDP included a support for alarms on the entrance and exit doors and backyard gates at his home. The support did not address how staff should monitor for potential elopement from the day program. CLDP supports in this area also did not address the need for staff to monitor for sexually inappropriate behavior.
        - For Individual #36, the supports for required supervision were also disjointed. In addition to the support described above, an earlier support in the area of recreation indicated he needed to be monitored by staff every 10 minutes at a minimum when using the sensory/quiet room at the day program. To ensure provider staff understanding of an individual's supervision needs as a whole, the IDTs should endeavor to create a concise and coherent support in this area.
        - Per the CLDP, both individuals needed to have a driver and one additional staff when being transported, but

the respective IDTs did not include this supervisory need in the supports.

- For Individual #171:
  - Per the 14-Day meeting documentation, he required the following medical consultations: neurology, primary care, psychiatry, gastroenterology (GI), and ear, nose and throat (ENT). The IDT developed a support for access to primary care, but not for any of the others.
  - Per the nursing and medical assessments, he had been seen in the ENT clinic for removal of paper impacted in his ears and required close monitoring around paper. The IDT did not develop a related support.
  - Per the SLP assessment, he required direct skilled services in the community, but the CLDP did not address this need with any supports.
- For Individual #36, the AMA indicated he would need follow-up consultations with neurology and GI, but the CLDP did not address the latter requirement.

- What was important to the individual: 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. While both CLDPs did address some outcomes important to each individual, neither CLDP did so assertively. Examples included:
  - For Individual #171, the IDT developed supports to address his ISP-identified interest in cooking, which was positive. On the other hand, the ISP also identified action plans to re-establish contact with aunt, including a SAP to dial a phone number, to create picture board to request calling, to call his aunt daily and visit aunt quarterly, and to video call with family. The ISP further stated he would need help making calls to his aunt. The CLDP contained a support for relationships under the quality of life heading, but it did not address these assertive approaches. One of the five components of the relationships support addressed his relationship with his aunt and cousins. It recommended the aunt be notified of his transition to the community and encouraged to re-connect; further, that these efforts should be continued in the community by the provider case manager. In addition to its lack of measurability, this support did not reflect an expected outcome for family contact or assertively address how that could be facilitated.
  - For Individual #36, the CLDP referenced his need for access to a quiet room, where he could listen to soft music. It indicated he needed a functioning radio within close proximity and provision of hand-over-hand assistance from staff in its use. It also indicated he had demonstrated an interest in playing an instrument in the quiet room. The CLDP included supports for the quiet room and radio, but did not include a support for selecting and using an instrument. It was positive that transition staff reported the provider was providing Individual #36 with an opportunity to use a keyboard, but it remained important to include needed supports in the CLDP rather than to rely on provider implementation in the absence of a formal support.
  - CLDPs should include supports that formalized an expectation that transition will offer enhanced opportunities for an individual to partake in community life as well as the normal rhythms of day-to-day home life. For these two CLDPs, the IDT set minimal/no expectations for meaningful day activities that emphasized community participation and integration. For example, Individual #36's CLDP only included a post-move recreation support under the heading of quality of life that indicated he would be offered outings at least once per week. In interview, transition staff reported he often spent time at a local multi-purpose center in the community, which was one of the several options included in the support for at-least-weekly outings. This was positive to hear; still, the CLDP needed to specify the expectation for

expanded opportunities rather than simply relying on the potential positive practices of the provider.

- Need/desire for employment, and/or other meaningful day activities. Neither CLDP addressed needs in this area in an assertive manner. Findings included:
    - For Individual #171, the vocational assessment described many positive attributes related to his work ethic, including that he was prompt, reliable, and followed directions well. The assessment further documented that he worked well with others and that once he learned a skill, he could be expected to work independently with minimal to no supervision. Finally, it noted that he liked to know his work was meaningful. The CLDP discussion was not fully consistent with this description. First, it indicated that he struggled to remain on task. The IDT then went on to document the provider was unable to support work in a similar manner as the Center, such as in a workshop where individuals work at their own pace and receive constant instruction and redirection. The IDT, therefore, concluded he would instead be supported with a consistent schedule of engaging activities, since work was not important to him. Neither of these conclusions was supported by the vocational assessment. In interview, transition staff reported they had also identified this discrepancy and discussed it with IDT members, but the CLDP did not document a discussion that justified a lack of work-related supports. Transition staff reported the provider had set up a shredding area for Individual #171 that he was using. While it was positive the provider had recognized and addressed this need, the CLDP still needed to have included appropriate formal supports.
    - While Individual #171's vocational support contained a number of components, it did not include a set of special instructions for work-related activities in the community found in the vocational assessment.
    - For Individual #36, the CLDP included extensive recommendations for activities in the day program as described in the Center's recreation assessment, which was positive, but did not address whether he had had a vocational assessment for workshop as recommended in his ISP. Such an assessment would likely have provided additional recommendations for meaningful day activities.

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. Both CLDPs addressed this sub-indicator with supports that met criterion, including specific reinforcement techniques in the behavioral supports as well as reinforcing and/or motivating activities.

- Teaching, maintenance, participation, and acquisition of specific skills: This was an area of positive practice. Both individuals had supports for specific teaching, maintenance, participation, and acquisition of specific skills and met criterion.
    - Individual #171's IDT developed supports for cooking classes and meal preparation and to continue a skill acquisition program for safety in the community.
    - Individual #36's CLDP included a support for continuing a skill acquisition program for using an adaptive switch to turn his radio off and on. In addition, his dining instructions focused on developing and maintaining his ability to feed himself.

- All recommendations from assessments are included, or if not, there is a rationale provided: El Paso SSLC had a process in place for documenting in the CLDP discussion of assessments and recommendations, including the IDT's rationale for any changes to, or additional, recommendations. The Monitoring Team noted this process was often used very effectively to identify and

	rectify issues related to clarity, measurability, and comprehensiveness. The CLDP format laid out the step-by-step consideration of recommendations from the pre-CLDP through the discussion and determination of final recommendations for supports. Still, for this review, the IDTs did not yet address all recommendations with supports or otherwise provide a justification as described above throughout this indicator. Per interview, State Office staff had also developed a draft CLDP template for each discipline assessment summary, which may help lead to further improvement in this area once fully implemented.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.												
Summary: The four indicators below will remain in the category of less oversight, however, the Monitoring Team has provided some comments regarding three of these indicators (4, 7, 8). With improvement in the list of pre and post move supports, it is likely that these indicators can also further improve in performance. They will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	36	171								
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.	0% 0/2	0/1	0/1								
7	If the individual is not receiving the supports listed/described in the CLDP, corrective action is implemented in a timely manner.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
8	Every problem was followed through to resolution.											
9	Based upon observation, the PMM did a thorough and complete job of post-move monitoring.	N/A	N/A	N/A								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	N/A	N/A	N/A								
Comments: 4. The PMM Checklists provided some good examples of documenting valid and reliable data. The PMM generally provided tremendous detail in her comments, often addressing more than what the support required as evidence. It was positive the PMM often												

went above and beyond the evidentiary requirements prescribed by the IDT. For example, several of Individual #171's behavioral supports required only a review of behavioral tracking sheets as evidence, even though provider staff knowledge was clearly called for. The PMM documented interviewing direct support staff as well as reviewing progress notes.

The Center should continue to focus on improving overall clarity and measurability of the pre and post move supports that provide guidance to the PMM as to what criteria would constitute the presence of various supports. At the time of the last monitoring visit, the Monitoring Team found that improvements in this area continued to be needed. As described above under Indicator 1, El Paso SSLC had continued to make progress in defining criteria for staff knowledge supports and specific competency criteria the PMM needed to be able to accurately collect valid data, but this was not yet consistent. Additional improvement was needed for the PMM to be able to consistently make accurate judgments about whether supports were being delivered as needed (this impacted performance on Indicators 5 and 6, as described below).

5. Based on information the Post Move Monitor collected, both individuals had received supports as listed and/or described in the CLDP. As described above, however, the Monitoring Team sometimes could not evaluate or confirm whether individuals had received all supports due to the lack clarity and measurability in the supports as written of reliable and valid evidence that demonstrated if supports were in place as required. For example, the available evidence did not provide confirmation that all provider staff had knowledge of either individual's active medical diagnoses and current plans of care as the support required.

6. Based on the supports defined in the CLDP, the Post-Move Monitor's scoring was frequently correct, but there were still some exceptions in which the evidence provided did not clearly substantiate the finding. In the example provided in Indicator 5 above, regarding provider staff knowledge of active medical diagnoses and current plans of care for both individuals, the PMM found those supports to be in place, even though the evidence provided could not justify that finding. Other examples included, but were not limited to:

- One of Individual #36's habilitation supports addressed staff assistance for walking and included five components. One of these components described staff actions to be taken for his safety if he became excited and increased stepping in place. The PMM Checklists did not address staff knowledge related to this requirement at any of the three PMM periods.
- On occasion, the PMM did not document interviewing direct support staff even when indicated as prescribed evidence. For example, a support for Individual #36 regarding antecedents to seizure activity indicated provider staff would be interviewed to confirm their knowledge, but the seven-day and 45-day PMM Checklist only indicated the provider nurse case manager had been interviewed.

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. This, in turn, relies on measurability of the supports and the collection of valid and reliable data to substantiate a determination of compliance with support requirements.

As described above, the Center continued to need to make improvements in describing measurable supports.

Still, it was positive the PMM consistently acted to ensure resolution when she was able to identify a concern.

9-10. There was no post move monitoring scheduled during the onsite week. Therefore, Monitoring Team did not participate in/observe post move monitoring. 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: Neither individual had a negative event (PDCT). This was good to see. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	36	171								
11	Individuals transition to the community without experiencing one or more negative Potentially Disrupted Community Transition (PDCT) events, however, if a negative event occurred, there had been no failure to identify, develop, and take action when necessary to ensure the provision of supports that would have reduced the likelihood of the negative event occurring.	100% 2/2	1/1	1/1								
Comments: 11. Neither individual had at a reported PDCT event.												

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: Areas of focus are transition assessments and pre-move training. Both topics were already on the transition department director's list of focus areas. Indicators 15 and 16 can likely be met by specific documentation of discussions that were already occurring and/or that could easily be held and documented. The Center continues to work well with the LIDDA and has met criteria for indicator 18 for three consecutive reviews. Therefore, indicator 18 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	36	171								
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	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										

	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.										
14	Facility staff provide training of community provider staff that meets the needs of the individual, including identification of the staff to be trained and method of training required.	0% 0/2	0/1	0/1							
15	When necessary, Facility staff collaborate with community clinicians (e.g., PCP, SLP, psychologist, psychiatrist) to meet the needs of the individual.	0% 0/2	0/1	0/1							
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 0/2	0/1	0/1							
17	Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual.	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. At the time of the last monitoring visit, transition staff had identified this as an area of need and were working toward improvement with various disciplines and through the pre-CLDP process. Transition staff had continued to implement positive strategies in this area, providing clinicians with both a checklist for what assessments needed to include as well as very specific feedback for needed revisions at the time of the pre-CLDP meeting. These were very positive practices and had resulted in some improved outcomes.

Findings for each of the sub-indicators used to evaluate compliance are provided below:

- Assessments updated with 45 Days of transition: Most assessments provided for review met criterion for timeliness. Examples of those that did not meet criterion were:
  - The Center did not provide an OT/PT assessment for Individual #171, nor did the CLDP document reviewing one. The CLDP indicated a QDRR was attached, but did not document the IDT reviewed its findings and recommendations.
  - For Individual #36, the Center did not provide a BHA for review, but should have based upon his needs. Per his ISP, he should also have had an assessment for the workshop, but no vocational assessment was provided. Upon request, the Center provided a FSA for review, but it was dated 2/8/17 and was therefore not within 45 days, but almost one year older.

- Assessments provided a summary of relevant facts of the individual's stay at the facility: Many discipline assessments provided a summary of relevant facts in the available assessments, which was a positive outcome of the good work transition staff had done to improve assessments. Missing assessments still negatively impacted this finding, however.
- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community and/or specifically addressed/focused on the new community home and day/work settings: All assessments did not yet meet criterion in this area, but improvement was noted. For example, Individual #171's communication assessment and Individual #36's residential and OT/PT assessments provided a good set of recommendations to support transition and community living. Examples of assessments that did not meet criterion included the FSA for Individual #171 as well as the outdated FSA for Individual #36.

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, as described below and in Indicator # 1 above, but the Center continued to make improvements in this area. Findings included, but were not limited to the following:

- As described under Indicator 1 above, the Center needed to continue to focus on the development of pre-move training supports that clearly identified the required competency criteria for provider staff that would be included in pre-move training and competency testing.
- At the time of the previous monitoring visit, the Monitoring Team found the Center needed to ensure its written exams were constructed to cover all essential knowledge. The Center continued to make some progress in this area, such as using open-ended questions that required provider staff to give written answers, rather than relying solely on true/false and multiple-choice responses. This format was more likely to elicit a true picture of provider staff knowledge. This was positive, but the Center continued to need to make additional improvements. Competency testing did not clearly document provider staff had knowledge of all prescribed supports based on each individual's needs. For example:
    - For Individual #171, competency testing did not address staff knowledge for any of the five components related to work-related activities under the heading of quality of life.
    - For Individual #36, competency testing did not address staff knowledge of the requirements for implementing a daily walking program to maintain strength and minimize bone loss. Specifically, the support called for Individual #36 to walk throughout the day at home and the day program. Per his pre-move training supports, this required the use of a wide heavy-duty gait belt. The support further required staff to be knowledgeable that he might push back and increase stepping in place when excited and described specific staff actions needed when this occurred. Competency testing questions did ask provider staff to name his adaptive equipment, but did not test staff knowledge of the other requirements.
    - Testing for Individual #36 also omitted many other support requirements, including, for example, movement instructions to use caution during handling due to brittle bones and instructions to seat him arms-length from peers especially on outings when he gets excited.
- In addition to ensuring thorough quizzes, the IDTs needed to consider other competency testing methodologies, such as return demonstration, when appropriate. For Individual #36, it was positive the training documented the provider staff observed his meal textures and transfers using the gait belt. To confirm staff ability to implement these supports, competency demonstration would be more appropriate than a paper exam.

- Pre-move training supports often called for the IDT to train key provider staff (such as the provider nurse) who would, in turn, train provider direct support staff. While this could be a viable model, it would still require the Center to confirm overall staff competence prior to transition. In interview, transition staff described some strategies it had used in the regard, including having direct support staff listen during the nurse-to-nurse training and take the competency test. The Center should formalize such practices in the CLDP as a part of its overall plan to ensure provider competence.

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. The IDTs still needed to provide a clear and comprehensive statement describing their full consideration of all collaboration needs.

16. SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs: 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. Individual #171's CLDP did not include a specific statement in this area. For Individual #36, the CLDP stated that team members visited the settings and decided clinician visits were not necessary because the homes modifications accommodated another individual with same supports. The IDT needed to provide a clear statement that such a decision was made by the appropriate disciplines and based on the unique needs of each individual.

17. Based on the individual's needs and preferences, SSLC and community provider staff engage in activities to meet the needs of the individual: The CLDP should include a specific statement of 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 Monitoring Team commends the Center for its positive practices in this area, such as involving Center direct support staff in pre-move provider visits in a meaningful way. Examples included the following:

- For Individual #171, the CLDP documented that preferred male staff from the Center attended his several overnight visits to model and ensure provider staff were providing supports as needed.
- For Individual #36, preferred Center staff also attended his extended overnight visit to provide in vivo training and modeling for provider staff.

18. The APC and transition department staff collaborate with the Local Authority staff when necessary to meet the individual's needs during the transition and following the transition: Both CLDPs met criterion.

19. The pre-move site reviews (PMSRs) for both individuals were completed prior to the transition date. It is essential the Center can directly affirm provider staff competency to ensure an individual's health and safety prior to relinquishing day-to-day responsibility, but the neither of these two PMSRs accomplished this.

- 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, pre-move supports required training sign-in sheets and paper exams with a passage rate of 100%, but the PMSRs included no evidence (other than a checked box) to

demonstrate the presence of these. Just as with the PMM Checklists, the staff completing the PMSR should provide a succinct comment about the evidence relied upon to verify the support was in place.

- As described above, the competency exams did not cover many of either individual's important needs and were insufficient evidence that provider staff were competent prior to transition.

Outcome 5 – Individuals have timely transition planning and implementation.

Summary: Both transitions surpassed the standard 180-day goal. For one, the transition log showed ongoing attention and activity. For the other, there were gaps in transition activity. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 36	171							
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 #171 was referred on 3/5/16 and transitioned on 8/8/18. This exceeded 180 days. Per the Transition Log, the IDT and/or QIDP did not always respond in a timely manner to requests for needed action from the APC's office. Per interview, transition staff indicated there had been some gaps in this transition process, due partially to some IDT turnover. It was positive transition staff reported they now attended the weekly IDT core meetings to provide and/or obtain needed information and action.
    - Individual #36 was referred 3/5/16 and transitioned on 2/12/18. This also exceeded 180 days, but met criterion. The Transition Log documented adequate ongoing activity by transition staff and the IDT to locate an appropriate setting

APPENDIX A – Interviews and Documents Reviewed

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

Documents:

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

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

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

For specific individuals who have moved to the community:

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

APPENDIX B - List of Acronyms Used in This Report

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

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

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