United States v. State of Texas

Monitoring Team Report

El Paso State Supported Living Center

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Background

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

In 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.

In 2021, the parties submitted to the Court, and the Court approved, various amendments and modification to the 2009 Settlement Agreement (now called the Amended Settlement Agreement). One of the modifications was the allowance of a Center to exit from a numbered provision, rather than solely from an entire lettered section, when sustained substantial compliance is demonstrated.

Methodology

In order to assess the Center's compliance with the Amended Settlement Agreement, the Monitoring Team undertook a number of activities:

a. Selection of individuals: During the weeks prior to the review, the Monitoring Team requested various types of information about the individuals who lived at the Center and those who had transitioned to the community. From this information, the Monitoring Team then chose the individuals to be included in the monitoring review. This non-random selection process is necessary for the Monitoring Team to address a Center's compliance with all provisions of the Settlement Agreement.
b. Onsite review: Due to the COVID-19 pandemic and resultant safety precautions and restrictions, the onsite review portion of this review was not conducted. Instead, the Monitoring Team used the Microsoft Teams audio and video platform to attend various meetings, conduct interviews of various staff members via Microsoft Teams (e.g., Center Director, Medical Director, Habilitation Therapies Director, Behavioral Health Services Director, Chief Nurse Executive, Lead Psychiatrist, QIDP Coordinator), and observe individuals and staff.

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 Center-wide documents. During the week of the review, the Monitoring Team requested and reviewed additional documents.
d. Observations: The Monitoring Team observed individuals in their homes, day/work sites, and other locations at the SSLC during regularly occurring activities. Specific activities were also scheduled and observed, such as administration of medication, implementation of skill acquisition plans, and conduct of mealtimes.
e. Interviews: The Monitoring Team 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 section of the Amended Settlement Agreement. 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 move to exited status. Exited indicators are not included in subsequent reports. The Monitor also makes a determination of whether an indicator will be moved to the category of requiring less oversight. Indicators that move to this category will not be scored, but may be monitored at future reviews if the Monitor has concerns about the Center'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 Center'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 Amended Settlement Agreement. Specifically, for each of the lettered sections of the Amended Settlement Agreement, the report includes the following sub-sections:

a. A status summary of sections and provisions that have exited and those that are in the category of requiring less oversight.
b. The outcomes and indicators are listed along with the Monitoring Team's scoring of each indicator.

c. The Monitor has provided a summary of the Center's performance on the indicators in the outcome, as well as a determination of whether each indicator will exit, move to the category of requiring less oversight, or remain in active monitoring.
d. The Monitor has provided comments to supplement the scoring percentages for many, but not all, of the outcomes and indicators.
e. Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers.

Executive Summary

The Monitoring Team wishes 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 Team during the remote review. The Center Director supported the work of the Monitoring Team 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 Team; their time and efforts are much appreciated.

During the review week, the Monitoring Team heard about and observed the various precautions and adjustments that the Center staff had made in order to respond to the risk of COVID infections. Center administration spoke highly about the extra efforts taken by staff at all levels.

Section C: Protection from Harm - Restraints

Substantial Compliance – Exited Status

Three of the provisions of this section met and achieved substantial compliance: C1, C2, and C4

Thus, the corresponding 11 monitoring indicators are no longer monitored or scored: 1-6, 8-12

Sustained High Performance – Less Oversight Status

Eight of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, three additional indicators were moved to this category.

Section Summary
Minutes of the Restraint Reduction Committee addressed ongoing issues with nursing (mostly related to timeliness in responding). In conversation, the Center noted high turnover and competing demand for nurse's time. For the six restraints reviewed, none of this resulted in any adverse outcomes for the individual. Even so, nursing completion of post-restraint injury assessment needs to occur as required.

The IDT did not always address the necessary components of restraint review to better understand and implement plans to reduce restraint when there were more than three restraints in 30-days for an individual.

The nursing-related indicators regarding crisis intervention restraint all met criteria with the indicators in the outcome.

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: This indicator is in the category of requiring less oversight, however, two of the six restraints in the review group did not meet criteria. Improvement should be made in order for this indicator to remain in this category after the next review. • For Individual #13 9/15/21, the IRIS form noted no injury, but IPN notes stated minor injury resulting from fall to the ground (which was part of the restraint process). • For Individual #190 105/21, the IRIS form noted that the nurse did not check for injury, although elsewhere there was information showing no	Individuals:

	injury (i.e., IPN at 4:19 pm). Thus, there was conflicting information that should have been resolved.										
#	Indicator	Overall Score									
7	There was no injury to the individual as a result of implementation of the restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
	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: The IRIS forms contained good descriptions of the restraint incident. Due to sustained high performance, indicator 13 will be moved to the category of requiring less oversight. Indicator 14 will remain in active monitoring for possible future review.			Individuals:								
#	Indicator	Overall Score	13	190	201						
13	A complete face-to-face assessment was conducted by a staff member designated by the facility as a restraint monitor.	100% 6/6	2/2	2/2	2/2						
14	There was evidence that the individual was offered opportunities to exercise restrained limbs, eat as near to meal times as possible, to drink fluids, and to use the restroom, if the restraint interfered with those activities.	N/A									
	Comments: The Monitoring Team chose to review six restraint incidents that occurred for three different individuals. Of these, all six 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.										

Outcome 5- Individuals' restraints are thoroughly documented as per Settlement Agreement Appendix A.											
Summary: Two of the six restraints did not meet criteria due to late or incomplete nurse assessment of post-restraint possible injury. This needs to be corrected if this indicator is to remain in active monitoring after the next review.			Individuals:								
#	Indicator	Overall Score									
15	Restraint was documented in compliance with Appendix A.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:

Outcome 6- Individuals' restraints are thoroughly reviewed; recommendations for changes in supports or services are documented and implemented.												
Summary: This indicator scored higher than ever before and, with sustained high performance, might move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	13	190	201							
16	For crisis intervention restraints, a thorough review of the crisis intervention restraint was conducted in compliance with state policy.	100% 6/6	2/2	2/2	2/2							
17	If recommendations were made for revision of services and supports, it was evident that recommendations were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.										
Comments:												

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: IDT review and discussion met criteria for indicator 20, but not for indicators 22 and 23. Performance, however, showed sustained high scores for indicators 25 and 28, both of which will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	190	201								
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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.										
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.											
20	The minutes from the individual's ISPA meeting reflected: 1. a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, 2. and if any were hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	100% 2/2	1/1	1/1								
21	(No longer scored)											

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?	50% 1/2	0/1	1/1							
23	The minutes from the individual's ISPA meeting reflected: 1. a discussion the variable or variables potentially maintaining the dangerous behavior that provokes restraint, 2. and if any were hypothesized to be relevant, a plan to address them.	0% 0/2	0/1	0/1							
24	If the individual had more than three crisis intervention restraints in any rolling 30 days, he/she had a current PBSP.	Due to the Center's sustained performance, these indicators were 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).	100% 2/2	1/1	1/1							
26	The PBSP was complete.	N/A									
27	The crisis intervention plan was complete.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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% 2/2	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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									

Comments:
These data are based on Individual #190's 11/17/21 ISPA and Individual #201's 8/17/21 ISPA to address more than three restraints in 30 days.

22. Individual #190's IDT suggested that peer taunting was an antecedent to his dangerous behavior that provoked his restraints, however, no action to address this potential antecedent to his aggression (e.g., separating him from peers that taunt him, etc.), was documented in his ISPA.

23. Both Individual #190's and Individual #201's ISPA's identified staff attention following dangerous behavior as a potential maintaining event. Neither ISPA, however, documented actions that would address this potential reinforcer (e.g., minimize the number of staff present, etc.).

Nursing: Outcome 1 - Individuals who are restrained (i.e., physical or chemical restraint) have nursing assessments (physical assessments) performed, and follow-up, as needed.

Summary: Criteria were met for all individuals for all crisis intervention restraints in the review group. With sustained high performance, one or more of these 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	13	190	201						
a.	If the individual is restrained, nursing assessments (physical assessments) are performed.	100% 6/6	2/2	2/2	2/2						
b.	If the individual is restrained using PMR-SIB:	N/A									
c.	The licensed health care professional documents whether there are any restraint-related injuries or other negative health effects.	100% 6/6	2/2	2/2	2/2						
d.	Based on the results of the assessment, nursing staff take action, as applicable, to meet the needs of the individual.	100% 3/3	2/2		1/1						

Comments:
a-d. Three out of three individuals who had crisis intervention restraint received a nursing assessment and follow-up as needed. Nurses were notified in a timely manner and provided assessment and documentation regarding occurrences, such as redness and/or skin tears resulting from the restraint.

Section D: Protection from Harm – Abuse, Neglect, and Incident Management

Substantial Compliance – Exited Status

El Paso SSLC achieved and sustained substantial compliance with Section D.

Thus, Settlement Agreement provisions D1 through D5 are exited and no longer monitored.

Thus, the corresponding 19 monitoring indicators (1 through 19) are no longer monitored or scored.

Section E: Quality Assurance

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary

With agreement of the Parties and the Monitor, monitoring of this section and its provisions is paused while the Center and State are receiving technical assistance and developing the Center and State quality assurance program.

Section F: Integrated Protections, Services, Treatments, and Supports

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary

In general, the QIDPs and direct support professionals were knowledgeable of the goals, strengths, and support needs of the individuals on their caseloads.

The IDTs continued to improve in developing good goals for individuals. Even so, none of the individuals had goals that met criteria for indicator 1 in all six ISP areas. All individuals, however, had goals in at least three areas that met criteria. This was about the same as at the last review.

Goals and action plans were based on individual preferences, but many provided little or no exposure to new opportunities to broaden the individual's base of experiences, and were often based on activities available at the Center.

The sets of action plans did not show how the individual might achieve goals. Action plans did not provide enough specificity or detail to guide implementation, or to assess progress and achievement. Many action plans were designed around participation or attendance rather than supporting individuals to gain skills that increase choice, decision-making, and self-determination.

None of the individuals had made measurable progress towards achieving their goals. Documentation did not support that the IDT addressed barriers to implementation and revised goals and action plans to address the lack of progress.

Some goals and action plans could potentially have been modified to support the individual during Covid-19 restrictions, moves, and staffing changes to help individuals to retain/maintain skills while unable to fully implement action plans.

For individuals of working age, goals should be designed to support obtaining meaningful work or jobs in a less restrictive settings. There was little focus on individualized job skills training.

QIDP reviews lacked sufficient substantive detail regarding whether progress was being made.

For most individuals, assessments were determined and updated, though none of the individuals had a full set of assessments submitted in time for ISP development. Participation by relevant disciplines was typically high at annual ISP meetings, whereas participation by individuals and their LARs was poor.

Outcome 1: The individual's ISP set forth personal goals for the individual that are measurable.

Summary: None of the individuals had goals that met criteria for indicator 1 in all six ISP areas. All individuals, however, had goals in at least three areas that met criteria. Overall, this was about the same as at the last review. More work is needed regarding health and wellness goals regarding actions the individual might take to improve his or her own health and wellness and address any IRRF/risks.

The Monitor has provided additional calculations to assist the Center in identifying progress as well as areas in need of improvement. For indicator 1, the data boxes below separate performance for the five personal goal areas from the health and wellness goals. The Monitoring Team looks at two health and wellness areas that rated as being at medium or high risk (in the IRRF) plus a dental goal if that area is rated as being at medium or high risk, plus suction toothbrushing if the individual receives suction toothbrushing.

Indicator 2 shows performance regarding the writing of goals in measurable terminology. Overall, about one-third of goals were written in measurable terminology.
Indicator 3 shows that overall, individuals did not have a robust set of action plans that might lead towards achievement of goals. Skill building opportunities were limited for all individuals. These three indicators will remain in active monitoring.

Individuals:

#	Indicator		Overall Score	91	198	201	119	13	115			
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.	Personal goals	0% 0/6 63% 19/30	2/5	4/5	4/5	3/5	3/5	3/5			
		Health goals	0% 0/6 6%	1/2	0/3	0/2	0/3	0/3	0/3			

			1/16									
2	The personal goals are measurable.	Personal goals	0% 0/6 44% 12/27 42% 8/19	2/5 0/2	2/4 2/4	2/5 1/4	2/5 2/3	2/4 1/3	2/4 2/3			
		Health goals	0% 0/6 0% 0/16 0% 0/1	0/2 0/1	0/3	0/2	0/3	0/3	0/3			
3	ISP action plans support achieving the individual's personal goals.		0% 0/6 18% 6/33	0/6	1/5	1/6	1/6	1/5	2/5			

Comments:
The Monitoring Team reviewed, in detail, the ISPs and related documents, interviewed staff, including DSPs and QIDPs, and directly remotely observed six individuals at the El Paso SSLC facility.

Individual #91 was admitted to the El Paso SSLC on 3/20/21. Little social history was known at the time of her admission other than she was born on 12/13/77 and raised by a neighbor in Dallas until the age of 21. Per documentation in her record, she could communicate with some simple words and complete most daily life activities with little assistance. According to her PSI, she enjoyed manipulating rubber mats, getting her nails done, looking nice, going out to parks, the zoo, the lake, out to eat, and having her own room and space. She consistently refused to attend vocational and day programming. Her ISP included few opportunities to learn new skills or try new activities. The IDT had determined that she could be served in a less restrictive setting, but did not recommend referral for community transition.

Individual #198 was 22 years old; he was admitted to El Paso SSLC on 2/21/17 (from El Paso Psychiatric Center). Prior to this, Individual #198 and his siblings lived with adoptive parents until he was 17 years old when he was placed in an HSC home due to aggressive behaviors. He attended the Texas School for the Deaf for a few months, but due to aggressive behaviors was not allowed to continue. He attended Americas High School and El Dorado High School while he was residing in the community. After admission to El Paso SSLC, he graduated from Jefferson High School. According to his PSI, he was independent in most daily life activities. He had profound hearing loss and used a single behind-the-ear hearing aid. He communicated using some basic signs and gestures. He was described as social, friendly, liked to play video games, make money, and ride his bike. The IDT had determined that he could be supported in a less restrictive setting, but did not recommend referral for community transition.

Individual #201 was recently admitted to the El Paso SSLC, on 3/20/21. Little social history was known at the time of her admission. Her ISP indicated she was mostly independent in her daily life activities, enjoyed music and singing, preferred privacy, liked to dress nicely, and used a computer and tablet. Due to behavioral concerns, the IDT had determined that Individual #201 could not be served in a less restrictive setting and did not recommend referral for community transition.

Individual #119 was 49 years old. She lived with her family until she was 16 when she was admitted to the El Paso SSLC on 7/11/88. Her ISP indicated she liked dolls, watching TV, swinging on patio swing, manipulating objects, and relaxing in her recliner. She did not communicate verbally, but understood Spanish and English with Spanish being her preference. She spent most of her day at home. Her ISP offered minimal opportunities for training and functional engagement. The IDT had determined that Individual #119 could be served in a less restrictive setting and recommended referral for community transition.

Individual #13 lived with his family until he was admitted to the El Paso SSLC on 3/20/98. He was 37 years old. He used single words, short phrases, and gestures to communicate. His ISP indicated that he enjoyed sports and watching the Dallas Cowboys, listening to regional Mexican music, working with the maintenance department, going out to eat, making money, and liked his independence. The IDT had determined that due to behavioral concerns, Individual #13 could not be served in a less restrictive setting and did not recommend referral for community transition.

Individual #115 turned 70 years old in October 2021. He was admitted to the Abilene State School in 1958 at the age of 7 then transferred to the El Paso SSLC on 7/15/86 where he since resided. His ISP indicated he preferred open spaces, communicated basic wants and needs, enjoyed spending time outdoors, wearing hats, and going on community outings. His IDT had been focused on teaching him to garden over the past year. He seemed to enjoy this activity and was learning new skills. Due to medical related concerns, the IDT had determined that he could not be served in a less restrictive setting and did not recommend referral for community transition.

1. None of the individuals had a comprehensive score that met criterion for the indicator. During the last monitoring visit, the Monitoring Team found 16 goals that met criterion for being individualized, reflective of the individuals' preferences and strengths, and were aspirational. For this review, an improvement was noted with 20 goals meeting this criterion:

- Recreation/Leisure: Individual #91, Individual #198, Individual #201, Individual #13, Individual #115
- Relationships: Individual #201, Individual #119
- Job/School/Day: Individual #198, Individual #201, Individual #115
- Independence: Individual #91, Individual #198, Individual #201, Individual #119, Individual #13
- Living Option: Individual #198, Individual #119, Individual #13, Individual #115
- Health/Safety: Individual #91

For all individuals, goals and action plans were built around individual preferences (which was good to see), and about half provided exposure to new opportunities to broaden the individuals' base of experience. Additionally, community-based activities were limited or on hold due to COVID-19 restrictions.

<u>Recreation/Leisure</u>*:*

Five individuals had recreation and leisure goals based upon interests that offered opportunities to learn new skills or engage in new leisure activities (Individual #91 will engage in a spa day once a month, Individual #198 will ride his bike to Azcarate Park two weekends per month, Individual #201 will perform in a talent show once per quarter, Individual #13 will attend three organized football games in the community, and Individual #115 will participate in growing his own personal garden).

Individual #119's goal in this area centered on creating a sensory station in her bedroom. It was positive that the IDT was providing her with new sensory items, but her goal did not indicate how this was related to providing her opportunities to engage in new recreational activities (she had opportunities to engage with sensory items throughout the day) or learn new skills that might expand her recreational opportunities.

Relationships:
Individual #119 and Individual #201's relationship goals were individualized, based, on their preferences and supported them to gain skills that would support relationship building opportunities.

Individual #198, Individual #13, and Individual #115 did not have a relationship goal. Their ISPs reflected few personal relationships, barriers to developing relationships, and communication barriers. The IDTs should consider developing strategies and supports to increase their ability to communicate with others, which in turn could potentially lead to increasing their ability to build interpersonal relationships and reduce peer-to-peer incidents.

Individual #91's goal to engage in manipulating items with peers appeared to be a compliance goal without a focus on building new skills or engaging in new recreational activities.

Job/School/Day:
Individual #198, Individual #201, and Individual #115 had goals that met criteria. Individual #198 had a goal to obtain a job in the community with a landscaping company. His goal was based on his work preferences and his current job at the center supported him to practice skills needed to work in the community. Individual #201 had a goal to work with the housekeeping department. Her vocational assessment indicated that this was one of her preferred jobs. Individual #115 had a goal that was based upon his interests and had action plans designed to support achievement. He was retired and the team agreed that he would enjoy learning how to grow his own personal garden.

During observations, Individual #91 was not engaged in functional activities. Her ISP offered few opportunities for functional training and few opportunities for exposure to new activities. She had a goal to earn more money, however, the IDT had not identified her vocational interests or skills needed to obtain her preferred job. Similarly, Individual #13 had a goal to earn money working, but the IDT did not identify specific work skills that might support him to work in a less restrictive environment. For individuals of working age, goals should be designed to support obtaining meaningful work or jobs in a less restrictive settings. There was little focus on individualized job skills training.

For Individual #119, the goal for attending the arts and crafts class at the El Paso Public Library was aspirational and offered opportunities for her to try new things in a less restrictive environment. However, it was unclear if this was based on her preferences

and interests or that potential work opportunities had been considered. This would have been much more in line with a possible relationship goal for her. Her ISP noted that she refused to engage in work offered at the on-campus sheltered workshop, but offered no detail on what type of work she had been offered. Her vocational assessment indicated that she did not receive vocational services and did not include any recommendations. Her goal was to be implemented four times per year, which did not provide an opportunity for her to be functionally engaged throughout her day. During observation, she was not functionally engaged.

Independence:
Five individuals had goals that met criteria for indicator 1 in terms of being based upon their preferences. However, Individual #119's goal "to create her own sensory station for her bedroom" was not specific in terms of how creating this sensory station reflected her specific preferences or how it would lead towards greater independence.

Living Option:
Living option goals were not individualized for Individual #201 and Individual #91. The goal merely stated, "will live in a group home." For the other four, goals met criteria by including some description based on known preferences.

Health/Safety:
It was nice to see that one individual had goals to support participation in improving or maintaining their own health and wellness.

- Individual #91: to address cardiac and weight, goals were identified to take nature walks daily to reduce waist girth to 40 in or less and to progress toward her ideal weight range of 117-143 pounds by losing ½ to 1 pound per month.

For the remaining five individuals, health risks had been identified and rated with goals related to health and wellness outcomes (e.g., medical, nursing, dental; see bulleted list below), but none included actions in which the individual might engage to address health and safety risks:

- Individual #198: respiratory, skin infections, neurology
- Individual #201: respiratory, cardiac, weight, neurology, medication side effects, behavioral health
- Individual #119: choking, aspiration, dental, weight
- Individual #13: respiratory, dental, cardiac, metabolic fractures, skin infections, neurology, medication side effects, behavioral health
- Individual #115: choking, respiratory, gastroenterology, cardiac, weight, metabolic, falls/fractures, skin integrity, neurology, medication side effects

2. Of the 20 personal goals that met criterion for indicator #1, eight also met criterion for measurability:

- Recreation/Leisure: Individual #198
- Relationships: Individual #119
- Job/School/Day: Individual #115
- Independence: Individual #201
- Living Option: Individual #198, Individual #119, Individual #13, Individual #115
- Health/Safety: none

An additional four goals that did not meet criteria for indicator #1 were measurable (Individual #201 and Individual #91's living option goals, Individual #91 and Individual #13's work goals).

For goals that were not measurable, the goal was not written in observable, measurable terms, did not indicate what the individual was expected to do, or how many times/how often they were expected to complete tasks/activities. Goals should include clear criteria for staff implementing the goal to determine when a goal has been met/mastered. For example, Individual #115's goal to choose a hat daily did not include completion criteria. Staff indicated that he routinely chose a hat when offered. It was not clear when this goal would be considered mastered. For Individual #198, the ISP narrative indicated that his goal would be to prepare a hamburger. It was not clear if the three recipes would be for different hamburgers, any recipe that was presented, the same recipe each quarter, etc.

3. For the 20 goals that met criterion for being personal and individualized, six had corresponding action plans that were supportive of goal-achievement. Action plans to support goals should include all necessary steps; be individualized; integrate strategies to reduce risk, incorporate needs included in ancillary plans; offer opportunities to make choices and decisions, where relevant; and support opportunities for functional engagement throughout the day with sufficient frequency, duration, and intensity to meet personal goals.

Goals that had action plans that were likely to lead to achievement of the goals were:

- Recreation/Leisure: Individual #198, Individual #201, Individual #115
- Job/School/Day: Individual #115
- Independence: Individual #119, Individual #13

Examples of goals that did not meet criteria:

- Individual #198's work goal to obtain a part-time job in the community with a landscaping company had accompanying action plans to reinforce participation in vocational/day programming and hygiene and to follow the daily schedule. There were no action plans to support him to seek employment in the community.
- Individual #201's work goal did not identify any job-related training that she might need to achieve her goal to work in with the housekeeping department.
- Action plans associated with Individual #13's living option goal to live in a small HCS group home near his father were broad statements, not individualized, and did not include teaching strategies and supports needed for consistent implementation and documentation.
    - Will have the opportunity to participate in community outings
    - Will be given the opportunity to participate in provider fairs held at El Paso SSLC
- Action steps related to Individual #91's greater independence goal to maintain her hair included SAPs to apply lotion and sign toilet. Training and support strategies did not relate to haircare.

Outcome 2: The individual's ISP set forth a plan to achieve goals.	
Summary: One goal had action plans that provided enough information to guide implementation, data collection, and assessment of progress. Overall, documentation did not provide details on whether the individual was making	Individuals:

measurable progress towards meeting their goals. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	91	198	201	119	13	115			
4	Each ISP action plan provided sufficient detailed information for implementation, data collection, and review to occur.	20% 1/5 17% 1/6	--	0/1	0/1	1/1	0/1	0/2			
5	There is documentation (e.g., data, reports, notes) that is valid and reliable to determine if the individual met, or is making progress towards achieving, each of the personal goals.	0% 0/5 14% 1/7	--	1/2	0/1	0/1	0/2	0/1			

Comments:
One goal's action plans (of the six that met criterion with Indicator #3), for Individual #119 (independence) provided specific detail to guide implementation, data collection, and assessment of progress.

For Indicator #5, for the eight goals that met criteria for Indicator #1 and #2, one met criteria for Indicator #5. Individual #198's QIDP noted in monthly reviews that he had not made progress towards his recreation leisure goal because action steps had not been implemented.

For the other seven goals, the QIDP commented on implementation of some action plans, but did not summarize specific progress towards the overall goal. For example, for Individual #13, the QIDP noted that action plans to support his goal to wash his clothes had been implemented, but did not comment on what specific progress he had made towards learning to wash his clothes.

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

Summary: None of the individuals had made measurable progress towards achieving their goals. Documentation did not support that the IDT addressed barriers to implementation and revised goals and action plans to address the lack of progress. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	91	198	201	119	13	115			
6	The individual met, or is making progress towards achieving, his/her overall personal goals.	0% 0/1 0% 0/1	--	0/1	--	--	--	--			
7	If personal goals were met, the IDT updated or made new personal goals.	N/A	--	--	--	--	--	--			

#	Indicator	Overall Score									
8	If the individual was not making progress, activity and/or revisions were made.	0% 0/1 0% 0/1	--	0/1	--	--	--	--			

Comments:
The QIDP monthly reviews indicated that Individual #198 had not made progress towards his recreation leisure goal because action plans had not been implemented. For all individuals, QIDP monthly review documented that action plans had not been consistently implemented; thus, individuals had made little progress was towards achievement of goals.

None of the individuals had achieved an ISP goal.

Individual #198's QIDP noted that no progress had been made towards his goal, but no action was taken by the IDT to address barriers to implementation or revise action plans.

Outcome 4: ISPs, assessments, and IDT participation support the development of a comprehensive and individualized annual ISP.

Summary: For most individuals, assessments were determined and updated; though none of the individuals had a full set of assessments submitted in time for ISP development. Overall, ISPs were not implemented timely. Although participation by relevant disciplines was typically high at annual ISP meetings, participation by individuals and their LARs was poor. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	91	198	201	119	13	115			
9	a. The ISP was revised at least annually (or was developed within 30 days of admission if the individual was admitted in the past year).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	b. 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			
10	The individual and all relevant IDT members participated in the planning process and attended the annual meeting.	17% 1/6	0/1	0/1	1/1	0/1	0/1	0/1			
11	a. The IDT considered what assessments the individual needed and would be relevant to the development of an individualized ISP prior to the annual meeting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
		0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			

	b. The team arranged for and obtained the needed, relevant assessments prior to the IDT meeting. c. Assessments were updated as needed in response to significant changes.	0% 0/1				0/1					

Comments:

9b**.** The ISP was not implemented within 30 days of the annual ISP meeting. For all individuals, multiple action plans had not been implemented. Plans that had not been implemented included:

- Individual #91: to engage in painting her nails; SAP for closing the lid of her hair product
- Individual #198: to ride his bike; washing hands before and after a meal; learning preferred signs
- Individual #201: participate in recreation events related to Bingo
- Individual #119: sensory board to be provided; painting a picture
- Individual #13: separate clothing to wash

10. One of the six individuals had an appropriately constituted IDT for the planning process that was based on their strengths, needs and preferences (Individual #201). Four of six individuals did not attend their ISP meetings. For one of four, the LAR/family did not attend. For the most part, there were broad statements included in the ISP that indicated individuals were invited/prompted/encouraged to attend and LARs/family were mailed letters with the date and time of the meeting. For two individuals, the SLP did not attend the meeting and communication was not addressed in a meaningful way in the ISP even though communication presented barriers to achieving goals.

Given that individual/LAR attendance is a core part of person-centered planning, the Center should focus on ways to increase individual and family participation. This might include offering a range of dates/times for meetings, including times that do not interfere with work and other daily activities, breaking the meeting up into smaller sessions with one session focused on input from the individual/family on goals and activities, and holding meetings in locations that the individual enjoys (e.g., park, coffee shop, library). A person's ISP should be focused on that person and any input that they want to offer to the team. This often may mean that the IDT needs to provide communication, behavioral, and other supports, when needed. ISP meetings should be meaningful to the individual and support them to feel empowered. Teaching/supporting self-advocacy should be part of the team process and addressed in the ISP when it is a barrier to participation. Findings included:

- Individual #91's ISP indicated she was informed about her ISP meeting, and she decided not to go to the meeting and engaged in another activity. Individual #91 did not have a LAR. The SLP did not attend her meeting though her limited communication skills were a barrier to forming relationships and being more independent.
- Individual #198's ISP indicated he was present at his meeting and used ASL to participate in the discussion to the best of his ability. His LAR was not present. The ISP indicated the LAR was sent a certified letter, but stated that he could not participate.
- Individual #201 participated in her ISP meeting with preferred staff and provided feedback regarding her goals for the ISP year. She was involved during her PSI meeting in which ISP goals were discussed and planned. She provided information on her strengths and preferences. Individual #201 did not have a LAR.
- Individual #119's ISP indicated she refused to participate in the meeting. Prior to the ISP, she was observed and assessed by all disciplines who provided services, however, assessments did not offer opportunities for her to try new activities so that she

might make an informed decision about how she would like to spend her day. Her strengths/preferences were used to develop new ISP goals but again, they were based on a limited range of exposure to new/other options. The QIDP did interview staff who worked longest with her. Individual #119's LAR was sent a certified letter and QIDP followed up with an email reminder. The LAR was present for the meeting.

- Individual #13 was not present for his meeting. His ISP indicated he was invited to his meeting, but preferred to engage in preferred leisure activities. The QIDP met with Individual #13 on the morning of his meeting to remind him of the time and informed his DSP to encourage him to attend. His LAR was present for the meeting.
- Individual #115 was not present at his ISP meeting. The ISP indicated he was tired and taking a nap at the time of the meeting. The IDT felt it was best for Individual #115 to nap because he needed to rest at times to avoid getting ill. His interests, preferences, and strengths were used to create his plans. Individual #115's LAR was present. The SLP was not present at his meeting. His ISP indicated that he communicated using gestures, pointing, reaching, leading behaviors, and refusals. His communication needs were not addressed.

During the post-review week meeting to review preliminary scoring, the Monitoring Team, Center, and State Office discussed this topic in further detail.

11b. All required assessments were not obtained prior to the IDT meeting for individuals reviewed. The facility reported they had recently hired two ISP Facilitators to support QIDPs in the ISP process.

11c. According to documentation, interviews, and observations the IDT had identified suspected cognitive decline with Individual #119, but had not subsequently arranged for assessments related to significant functional changes.

Outcome 5: The individual's ISP identified the most integrated setting consistent with the individual's preferences and support needs.

Summary: More work is needed on documenting a thorough discussion regarding living options and then developing action plans that are individualized based on identified preferences and support needs. These indicators remain in active monitoring.

#	Indicator	Overall Score	Individuals: 91	198	201	119	13	115			
12	There was a thorough examination of living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
13	a. 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			
	b. The IDT considered opportunities for day programming in the most integrated setting consistent with the individual's preferences and support needs.	33% 2/6	0/1	1/1	0/1	1/1	0/1	0/1			

14	ISP action plans included individualized-measurable plans to educate the individual/ LAR about community living options.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
15	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			

Comments:
12. None of the ISPs for the six individuals included a thorough examination of living options and the advantages of how community living could benefit the individuals.

13a. None of the ISPs had action plans that were likely to lead towards community integration. Action plans provided little or no exposure to new opportunities to broaden individual's base of experience. Although some individuals had goals to participate in community activities, work, or live in the community, their action plans were not supportive of those goals and were unlikely to lead towards true integration.

13b. Two ISPs (Individual #198, Individual #119) considered opportunities for day programming in the most integrated setting consistent with preferences and support needs. Day and work opportunities by and large were limited for most individuals and focused on what was available at the facility without focusing on building skills that could potentially lead towards employment in a more integrated setting

14. None of the ISP action plans included individualized measurable plans to educate the individual/ LAR about community living options. Individuals had broadly stated action plans to provide information to the individual and LAR annually, attend provider fairs, and/or go on community tours. Action plans centered around a "readiness" or "stability" approach rather than on providing opportunities to enhance the individual's understanding of living options and the benefits of community living.

- Individual #91:
  - Will visit group homes for community awareness/education
  - Will continue to go on community outings to obtain community exposure
- Individual #198:
  - Will meet his PBSP goals for 6 consecutive months
  - Will meet the behavioral contract requirements for 6 consecutive months
  - Will participate in biannual tours, virtually of community homes
- Individual #201:
  - Will meet her behavioral objective for 12 consecutive months
  - Will participate in group home tours
  - Will participate in provider fairs
- Individual #119:
  - Will meet her behavioral goals for 6 consecutive months
  - Continue transportation desensitization program
  - SAP: body spray

- Individual #13:
  - Will be given the opportunity to participate in community outings
  - Will be given the opportunity to attend provider fairs
- Individual #115:
  - Will attend provider fairs twice a year
  - Will be provided with information in regard to community living

15. IDTs had not created individualized, measurable action plans to address identified obstacles to referral. Action plans were broadly stated and did not address a path for living in a less restrictive setting and the benefits of community living.

Outcome 6: Individuals' ISPs are implemented, progress is reviewed, and supports and services are revised as needed.											
Summary: Staff were, for the most part, knowledgeable of the individuals they supported. This has been the case for a number of successive reviews. Therefore, indicator 16 will be moved to the category of requiring less oversight. ISP action plan implementation and revisions to actions when there was no progress remained in need of improvement. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	91	198	201	119	13	115			
16	Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans.	100% 4/4		1/1	1/1		1/1	1/1			
17	Action plans in the ISP were consistently implemented.	17% 1/6	0/1	0/1	0/1	0/1	0/1	1/1			
18	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:
16. Staff were knowledgeable of the individual's support needs, risk areas, ISP goals, and action plans. While remote observations were limited, and somewhat awkward for staff and individuals, staff were observed providing respectful and positive interactions. This indicator was not scored for two individuals because observations were particularly limited, and it was difficult to assess staff knowledge.

17. For five of the six individuals, action plans had not been implemented and individuals had not made progress towards most goals. The exception being Individual #115 where there was consistent implementation of all action plans. There was a total of 48 action steps evaluated. Six (13%) were on hold either due to COVID-19 community gathering restrictions or behavioral/health concerns that impacted individual's ability to participate in implementation. There was no evidence that IDTs considered alternate training

opportunities while action plans were on hold. Of the 42 action plans that could be implemented, 13 (31%) reflected consistent implementation.

Two individuals had six action plans across six goal areas, two individuals had seven, one had nine, and the other had 13. Five individuals had at least one action plan that was on hold due to Covid-19 restrictions. As noted throughout this section of the report, training and opportunities for meaningful engagement were extremely limited.

Individual	# Of Action Steps in ISP	Action Steps Implemented	Action Steps On- Hold	Action Steps Not Fully Implemented
Individual #91	7	1	1	6
Individual #198	7	1	1	5
Individual #201	13	0	2	11
Individual #119	9	3	0	6
Individual #13	6	2	1	3
Individual #115	6	6	1	0

18. QIDPs did not ensure the individual received required monitoring/review and revision of treatments, services, and supports. It was good to see that QIDPs were consistently reviewing goals and action plans and commenting on progress, however, commentary was not substantive in terms of assessing needed revisions, barriers to full implementation, progress, or lack of progress.

Section G: Integrated Clinical Services

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

For pretreatment sedation, proper procedures were followed for pretreatment for dental procedures, but not for medical appointments or procedures.

For outside medical-related specialty consultations, criteria were met for about half of the cases for the three monitoring indicators that were not in less oversight.

Outcome 6 – Individuals receive dental pretreatment sedation safely.											
Summary: Proper procedures were followed for two individuals requiring general anesthesia for dental care. These indicators will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	If individual is administered total intravenous anesthesia (TIVA)/general anesthesia for dental treatment, proper procedures are followed.	100% 2/2						1/1			1/1
b.	If individual is administered oral pretreatment sedation for dental treatment, proper procedures are followed.	N/A									

Comments:
a. Proper procedures were followed for the two individuals (Individual #161 on 8/23/21 and Individual #42 on 8/23/21) who required general anesthesia for dental treatment during the review period.

b. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in the review group were administered oral pretreatment sedation for dental procedures.

Outcome 11 – Individuals receive medical pretreatment sedation safely.											
Summary: Proper procedures were followed in regard to oral pretreatment sedation for one individual. This indicator will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	If the individual is administered oral pretreatment sedation for medical treatment, proper procedures are followed.	33% 1/3		0/1				0/1		1/1	

Comments:

Pretreatment sedation was reviewed for three individuals:

- Individual #201 received pretreatment sedation prior to a cardiology appointment on 11/15/21. Dates of the pre and post sedation notes were 11/15/21 and 11/16/21. Lorazepam 4 mg was given at 11:20 am on 11/15/21. The individual refused vitals after sedation was given. There was no consent submitted in response to the document request. IDT notes indicated that the team, including the PCP discussed dosage and recommended that the IDT meet after the appointment. No further team notes on this topic were submitted.
- Individual #161 received pretreatment sedation prior to a gynecology appointment on 7/20/21. There was an initial pre-sedation note, however, vital signs were not included. The post-sedation note had heart rate and pulse oximetry, but no BP or respiratory rate. There was no post-sedation checklist submitted.
- Individual #13 received pretreatment sedation on 8/30/21. Documentation confirmed that proper procedures were followed to ensure that he received pretreatment sedation safely.

Outcome 7 – Individuals' care and treatment is informed through non-Facility consultations.											
Summary: PCPs were not always reviewing consultations in a timely manner. IPNs generally included all required components. More work is needed to ensure that IDTs review all recommendations and develop a plan to address when necessary. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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, this indicator moved to the category requiring less oversight.									
b.	PCP completes review within five business days, or sooner if clinically indicated.	60% 9/15	2/2	0/2	1/2	2/2	0/1	2/2	0/1	1/1	1/2
c.	The PCP writes an IPN that explains the reason for the consultation, the significance of the results, agreement or disagreement with the	80% 12/15	2/2	2/2	2/2	1/2	0/1	2/2	0/1	1/1	2/2

	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.	Due to the Center's sustained performance, this indicator moved to the category requiring less oversight.									
e.	As the clinical need dictates, the IDT reviews the recommendations and develops an ISPA documenting decisions and plans.	50% 2/4		2/2						0/1	0/1

Comments:

For the nine individuals, the Monitoring Team reviewed a total of 15 consultations. The consultations reviewed were:

- Individual #198 – gastroenterology on 9/7/21 and infectious disease on 9/20/21
- Individual #201 – cardiology on 6/23/21 and 7/26/21
- Individual #118 – surgical on 7/29/21 and ophthalmology on 8/4/21
- Individual #102 – wound clinic on 12/2/21 and urology on 8/26/21
- Individual #162 – gastroenterology on 12/13/21
- Individual #161 – internal medicine on 9/1/21 and cardiology on 8/6/21
- Individual #115 – orthopedic/podiatry on 10/22/21 for routine foot care
- Individual #13 – orthopedic/podiatry on 7/20/21
- Individual #42 – gastroenterology on 7/13/21 and 10/25/21

b. The following reviews did not occur timely:

- Individual #201 for cardiology consult on 6/23/21 and 7/26/21
- Individual #118 for ophthalmology consult on 8/4/21
- Individual #162 for gastroenterology consult on 12/13/21
- Individual #115 for orthopedics/podiatry consult on 10/22/21
- Individual #42 gastroenterology consult on 7/13/21

c. Twelve of 15 of the PCP IPNs related to the consultations reviewed included all the components State Office policy required. The exceptions were:

- Individual #102 for wound clinic on 12/2/21,
- Individual #162 for gastroenterology on 12/13/21, and
- Individual #115 for orthopedics/podiatry on 10/22/21.

e. For two of four consultations, where warranted, the IDT reviewed the recommendations and developed an ISP documenting the IDT decisions and plan.

- For Individual #201, the IDT met following the cardiology consult 6/23/21 and on 7/26/21. The IDT discussed weight issue identified by the cardiologist, however, the ISPA lacked sufficient detail to understand what would be

implemented and how it would be monitored. The IDT discussed exercise, but failed to outline what physical activity would be and would it meet the generally accepted needs for an adult to have impact on her weight gain. The IDT did not consider the potential impact of medication or other issues that might contribute to her weight gain. They did recommend diet changes, however, some of the proposed substitutions would substitute a higher calorie item (e.g., Boost pudding) for a lower calorie one (e.g., regular pudding).

- Individual #13 refused to get out of the van for his podiatry appointment. The IDT did not develop a plan to address his appointment refusals
- For Individual #42, there was no documentation of an ISPA related to the GI consult and recommendations.

Section H: Minimum Common Elements of Clinical Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section I: At-Risk Individuals

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section have been moved to the category of requiring less oversight.

Section Summary
Performance improved on both indicators since the last review. Risk ratings were accurate and timely for the most part.

Section I: Risk management											
Nursing Risk: Outcome 1 – Individuals at-risk conditions are properly identified.											
Summary: Performance improved on both indicators since the last review. Risk ratings were accurate and timely for the most part. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	102	118	115	162			
a.	The individual's risk rating is accurate.	92% 11/12	1/2	2/2	2/2	2/2	2/2	2/2			
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.	67% 8/12	1/2	2/2	1/2	0/2	2/2	2/2			

Comments:
a. Eleven of the 12 risk areas reviewed were determined to have an accurate risk rating score.
b. Eight of 12 (67%) of the IRRFs completed were done so in a timely manner.

- For Individual #198 (GI), Individual #102 (GI), and Individual #118 (weight), their IRRF was not updated within the five days needed in the event of a change in status. For Individual #118, the annual was completed in a timely manner, but the there was an absence of an IRRF review/update within five days of a clinical status change in April 2021 and July 2021.

Section J: Psychiatric Care and Services

Substantial Compliance – Exited Status

Seven of the provisions of this section have met and achieved substantial compliance: J6, J7, J9, J10, J11, J14, J15.

Thus, the corresponding 18 monitoring indicators are no longer monitored or scored: J1-3, 13, 15, 22, 24, 25-27, 28-32, 44-46.

Sustained High Performance – Less Oversight Status

Sixteen of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary
The Center's long-term psychiatrist (more than six years) left the Center in July 2021. Currently, there was a locum tenens psychiatrist. He was available to the facility 40 hours each week, including being onsite two days a week for clinic.

It was good to see that the psychiatry department was identifying psychiatric indicators for reduction and increase and was defining these indicators. They were documenting how the indicators related to the individual's specific diagnosis and they were writing goals associated with each indicator. The goals were more regularly entered into the facility's overall treatment program, the IHCP. Three individuals, however, did not have data reported for one or both indicators.

One-third of individuals were demonstrated (via reliable data) to be making progress and/or maintaining stability. If an individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made (but not always implemented).

With the change in psychiatry staff, there was some decline in the documentation quality, completeness, and timeliness:

- Psychiatrist/prescriber review of side effect assessments.
- CPE content.
- Psychiatric diagnoses consistency throughout the different sections and documents in the record.
- ISP final document essential elements.
- Nine components of the quarterly review document.
- Documentation content of emergency/interim clinical encounters.

Outcome 2 – Individuals have goals/objectives for psychiatric status that are measurable and based upon assessments.											
Summary: At El Paso SSLC, there was maintenance of progress in the sub-indicators of each of the indicators in this outcome, with overall scores slightly lower than in the previous monitoring period for indicators 4 and 5. Indicators 6 and 7 showed improvement. The psychiatry department was identifying indicators for reduction and increase as well as defining these indicators. The psychiatry department was documenting how the indicators related to a specific diagnosis and was writing goals associated with each indicator. The goals were more regularly entered into the facility's overall treatment program, the IHCP. There were issues with the production and reliability of data for some of the individuals. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
4	Psychiatric indicators are identified and are related to the individual's diagnosis and assessment.	78% 7/9	2/2	2/2	2/2	1/2	1/2	2/2	2/2	2/2	2/2
5	The individual has goals related to psychiatric status.	78% 7/9	1/2	2/2	2/2	1/2	2/2	2/2	2/2	2/2	2/2
6	Psychiatry goals are documented correctly.	56% 5/9	2/2	1/2	2/2	1/2	1/2	2/2	2/2	2/2	1/2
7	Reliable and valid data are available that report/summarize the individual's status and progress.	44% 4/9	0/2	2/2	0/2	1/2	2/2	1/2	0/2	2/2	2/2

Comments:

The scoring in the above boxes has 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.

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 an individual's 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.

In psychiatry, the focus is upon what have come to be called psychiatric indicators. Psychiatric indicators can be measured via recordings of occurrences of indicators directly observed by SC staff. Another way is to use psychometrically sound rating scales that are designed specifically for the psychiatric disorder and normed for this population.

The Monitoring Team looks for:

a. The individual to have at least one psychiatric indicator related to the reduction of psychiatric symptoms <u>and</u> 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 as all individuals in the review group had one or more psychiatric indicators related to the reduction of psychiatric symptoms, and these were related to the diagnosis and defined in observable terminology. Thus, for all individuals in the review group, all three of the above sub-indicators were met.

Seven of the individuals in the review group had psychiatric indicators for increase in positive/desirable actions identified. These were generally either increase in nightly sleep hours or replacement behaviors reviewed by psychiatry with statements included in the psychiatry goals grid relating the identified indicator to the individual's psychiatric diagnosis.

Thus, criteria were met for all three sub-indicators (a, b, c) for psychiatric indicators for reduction for all individuals in the review group and for seven of the individuals for psychiatric indicators for increase. Two individuals, Individual #91 and Individual #30, either did not have indicators for increase identified or there was a need to clarify the indicator, resulting in the 1/2 scores above.

<u>5. Psychiatric goals</u>:

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.

The psychiatric goals regarding the indicators for increase and decrease met monitoring criteria in that they included a measurement, the modality or scale that would be used to obtain the measurement, and a time metric. While the psychiatry goals grid did not indicate who was responsible for the gathering or trending of data, this information was included in the psychiatry quarterly clinical documents where it was noted that staff would enter information into care tracker, data would be compiled/analyzed by behavioral health staff, and would be presented to the IDT during psychiatry clinic via the presentation of the integration tool.

As the purpose of the psychiatric indicator is to determine an individual's symptom experience, a mixture of individually defined indicators and/or data from direct observations by staff of psychiatric indicators with goals <u>and</u> the collection of data utilizing rating scales normed for this population could be considered.

Thus, both sub-indicators were met for seven of the individuals for goals for reduction and for goals for increase. Individual #23 did not have a clear determination regarding data collection for his indicator for increase and Individual #91 did not have an indicator for increase identified, resulting in the 1/2 scores above.

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, goals for reduction and increase were written for the identified indicators and documented in the psychiatry goals grid. There was an improvement with regard to the incorporation of the goals into the Center's overall documentation system, the IHCP. All individuals in the review group had a goal for decrease entered into the IHCP. Five individuals in the review group had a goal regarding the indicator for increase included in the IHCP. If the goal was updated over the course of the year, these updates, although included in the psychiatry goals grid, were not routinely added to the IHCP.

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.

At El Paso SSLC, data were reported for psychiatric indicators for reduction and increase. These data, while generally graphed for the presentation in psychiatry clinic and presented via the integration tool, were then included in the psychiatry clinical notes as a list of months with totals of events occurring during that period of time. Data presented in clinical and review meetings were generally up-to-date, and as noted above were graphed and trended with documentation of the behavioral health analysis of the data.

There were issues with data collection and reliability for some individuals. Despite having indicators for reduction and increase identified, there were no data available for review regarding Individual #23. For Individual #190, data were not included in the psychiatry reviews until December 2021, with data presented for September through December 2021. Although indicators were established as of June 2021, no data were presented for June through August 2021. Data presented regarding Individual #173 were not reliable. Individual #91 did not have an indicator for increase identified, so there were no data presented and for Individual #35 the goal for the indicator for increase required the calculation of a percentage of total opportunities. The presentation of the data regarding this indicator did not allow for the calculation as only the number of times the behavior occurred was presented, not the total number of opportunities.

Outcome 3 – All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Indicators 8 and 9 scored higher than ever before. Psychiatry made revisions to treatment when there was no progress or worsening conditions. This has been the case for a number of successive reviews and, as a result, indicator 10 will be moved to the category of requiring less oversight. The other indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119

#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
8	The individual is making progress and/or maintaining stability.	33% 3/9	0/2	2/2	1/2	0/2	2/2	2/2	0/2	0/2	1/2
9	If goals/objectives were met, the IDT updated or made new goals/objectives.	100% 2/2	1/1								1/1
10	If the individual was not making progress, worsening, and/or not stable, activity and/or revisions to treatment were made.	100% 8/8	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	
11	Activity and/or revisions to treatment were implemented.	75% 6/8	1/1	0/1	0/1	1/1	1/1	1/1	1/1	1/1	

Comments:
8-9. Per a review of the individual's goals and indicators as well as available data, there were individuals who were making progress toward their treatment goals. There were also individuals where it was apparent that goals needed adjustment. The psychiatry department did a good job of reviewing the available data and the individual's progress toward their treatment goals as well as writing new/updated goals when necessary and including them in the psychiatry goals grid.

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) were developed and implemented. There were individuals in the review group who were noted per their treating psychiatrist to be psychiatrically stable, however, some individuals with this designation were noted to have adjustments to their medication regimen or behavior management program. The exception to this was Individual #119 who was noted to be stable by the treating psychiatrist with no need for adjustments to her treatment program. One issue identified was that two individuals were referred for counseling to address behavioral health symptoms and diagnoses. These two individuals, Individual #190 and Individual #7, were reportedly not receiving the recommended intervention, but psychiatry was not aware of the gap in service.

Outcome 4 – Individuals receive comprehensive psychiatric evaluation.

Summary: Performance on indicator 14 was higher than in previous reviews and performance on indicator 16 was lower than at the last review. Both will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 23	7	190	91	30	35	173	201	119
12	The individual has a CPE.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
14	CPE content is comprehensive.	44% 4/9	0/1	1/1	0/1	1/1	0/1	1/1	0/1	1/1	0/1
16	All psychiatric diagnoses are consistent throughout the different sections and documents in the record; and medical diagnoses relevant to psychiatric treatment are referenced in the psychiatric documentation.	67% 6/9	0/1	1/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1

Comments:
14. The Monitoring Team looks for 14 components in the CPE. Four of the CPEs included all of the required components. The remaining five evaluations were missing one or two elements. • The evaluation regarding Individual #23 was missing laboratory examinations and an adequate bio-psycho-social formulation. • The evaluation regarding Individual #190 was missing laboratory examinations. • The evaluation regarding Individual #30 was missing the social history. • The evaluation regarding Individual #173 was missing the physical examination. • The evaluation regarding Individual #119 was missing an adequate bio-psycho-social formulation. 16. There were three individuals whose records revealed inconsistent diagnoses, Individual #23, Individual #30, and Individual #173. • For Individual #23, the AMA incorrectly included a diagnosis of Schizoaffective Disorder. • For Individual #30, both the AMA and the BHA incorrectly included a diagnosis of Major Depressive Disorder. • For Individual #173, both the AMA and the BHA incorrectly included a diagnosis of Attention Deficit Disorder.

Outcome 5 – Individuals' status and treatment are reviewed annually.											
Summary: This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
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 (i.e., annual psychiatric treatment plan).										
19	Psychiatry documentation was submitted to the ISP team at least 10 days prior to the ISP and was no older than three months.										
20	The psychiatrist or member of the psychiatric team attended the individual's ISP meeting.										
21	The final ISP document included the essential elements and showed evidence of the psychiatrist's active participation in the meeting.	56% 5/9	1/1	1/1	1/1	0/1	0/1	1/1	0/1	1/1	0/1
Comments: 21. In four examples, regarding Individual #91, Individual #30, Individual #173, and Individual #119, 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 7 – Individuals receive treatment that is coordinated between psychiatry and behavioral health clinicians.	
Summary:	Individuals:

#	Indicator	Overall Score									
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
	Comments:										

Outcome 10 – Individuals' psychiatric treatment is reviewed at quarterly clinics.											
Summary: These three indicators are in the category of requiring less oversight and they will remain in this category. However, performance during this review period was lower than in the past (about 50%)			Individuals:								
#	Indicator	Overall Score									
33	Quarterly reviews were completed quarterly.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
34	Quarterly reviews contained required content.										
35	The individual's psychiatric clinic, as observed, included the standard components.										

Comments:

33. Quarterly reviews were completed in a timely manner for four individuals in the review group. Individual #23, Individual #7, Individual #91, Individual #173, and Individual #119 were missing quarterly evaluations in July 2021. This was a period during which the facility was in the process of recruiting a new psychiatrist to fill the psychiatry position vacated in late June 2021. The evaluations for these five individuals were completed after a one- month delay, in August 2021.

34. The Monitoring Team looks for nine components of the quarterly review. Four of the examples included all the necessary components. The remaining five evaluations were missing each missing one component.

- The quarterly evaluation regarding Individual #23 did not include data.
- The quarterly evaluation regarding Individual #7 did not include information regarding non-pharmacological interventions.
- The quarterly evaluation regarding Individual #190 did not include information regarding non-pharmacological interventions.
- The quarterly evaluation regarding Individual #91 did not include the results of the most recent MOSES and AIMS.
- The quarterly evaluation regarding Individual #201 did not include the psychiatric diagnosis with a description of symptoms that support the diagnosis.

35. During the virtual monitoring visit, psychiatry clinic was observed with the facility psychiatrist for three individuals, two of whom, Individual #23 and Individual #7, were included in the review group. In addition, neuro-psych clinic was observed for two individuals. In the clinical encounter regarding Individual #23, no data were reported as behavioral health indicated that data were not being collected. As such, it was not possible to make data driven decisions regarding Individual #23' medication regimen.

In all clinical encounters observed, the psychiatry clinic licensed vocational nurse was in charge of the clinic, essentially directing staff participation. The physicians were observing the clinical encounter and periodically asking questions. The psychiatrist should take more of a leadership role in directing clinic, to ensure that appropriate information is provided to allow for clinical decision making as well as explaining/reviewing the decision-making process such that the plan for ongoing care is clear to the IDT.

There also was a need for improvement with regard to the discussion of the presented information and what that information meant clinically with regard to the need to adjust treatment interventions.

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

Summary: These assessments were conducted (which was good), but they were not reviewed and/or not reviewed timely by the prescriber. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 23	7	190	91	30	35	173	201	119
36	A MOSES & DISCUS/AIMS was completed as required based upon the medication received.	22% 2/9	0/1	0/1	1/1	0/1	0/1	1/1	0/1	0/1	0/1

Comments:

36. There were delays in the completion of MOSES and DISCUS assessments and in the prescriber review for seven individuals in the review group.

- For Individual #23, the AIMS dated 7/21/21 was not reviewed by the prescriber.
- For Individual #7, the AIMS dated 7/12/21 was not reviewed by the prescriber.
- For Individual #91, the AIMS dated 4/14/21 was not reviewed by the prescriber until 5/11/21. The MOSES and AIMS dated 11/16/21 were not reviewed by the prescriber.
- For Individual #30, the MOSES assessments dated 2/11/21, 8/19/21, and 9/13/21 were not reviewed by the prescriber.
- For Individual #173, the AIMS and MOSES assessments dated 4/7/21 were not reviewed by the prescriber until 4/27/21. The AIMS dated 7/15/21 was not reviewed by the prescriber. The AIMS and MOSES assessments dated 11/15/21 were not reviewed by the prescriber.
- For Individual #201, the AIMS and MOSES assessments dated 11/30/21 were not reviewed by the prescriber.
- For Individual #119, the AIMS and MOSES assessments dated 7/8/21 were not reviewed by the prescriber.

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

Summary: Indicator 39 will remain in the category of requiring less oversight, however, as detailed in the comments below, documentation of interim clinics needs to return to prior levels of high performance. The Monitoring Team understands that this is one area that the new psychiatry staff are attending to.

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:
39. There was documentation of emergency/interim clinical documentation regarding four of the individuals in the review group, Individual #7, Individual #91, Individual #173, and Individual #201. The documentation from these emergency/interim clinical encounters, regarding Individual #91, Individual #173, and Individual #201, specifically when medication adjustments were made, did not include adequate information to justify the prescriber's decision to adjust the medication regimen.

Outcome 13 – Individuals do not receive medication as punishment, for staff convenience, or as a substitute for treatment.

Summary: | Individuals:

#	Indicator	Overall Score									
40	Daily medications indicate dosages not so excessive as to suggest goal of sedation.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
41	There is no indication of medication being used as a punishment, for staff convenience, or as a substitute for treatment.										
42	There is a treatment program in the record of individual who receives psychiatric medication.										
43	If there were any instances of psychiatric emergency medication administration (PEMA), the administration of the medication followed policy.										

Comments:

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 crisis intervention restraints reviewed as part of the review group. In fact, there was only one crisis intervention restraint during the entire review, back in early May 2021. This indicator will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
47	The form Administration of Chemical Restraint: Consult and Review was scored for content and completion within 10 days post restraint.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
48	Multiple medications were not used during chemical restraint.										
49	Psychiatry follow-up occurred following chemical restraint.	N/A									
Comments:											

Section K: Psychological Care and Services

Substantial Compliance – Exited Status

Four of the provisions of this section have met and achieved substantial compliance: K3, K5, K7, K11.

Thus, the corresponding seven monitoring indicators are no longer monitored or scored: K2-4, 10, 17, 22-23.

Exiting of provision K3 (indicators 22-23) was based upon 2014 performance.

Sustained High Performance – Less Oversight Status

Ten of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, two additional indicators were moved to this category.

Section Summary
At the last review, there were four behavioral health specialists (including the director), three of whom had BCBA certification. The director and one of the behavioral health specialists recently left the Center. They had not yet been replaced. The interim BHS director was currently the only BCBA on staff.

El Paso SSLC continued to attend to PBSP data reliability and PBSP implementation. To be specific, IOA, DCT, and treatment integrity assessments occurred at the objective frequency level for eight of nine individuals.

For the seven (of eight) individuals for whom there were reliable PBSP data, three were making progress. For the other four, one or more aspects of behavioral health supports were not in place at criteria.

In some cases, when objectives were met, they were updated. Similarly, in some cases, when progress was not occurring, actions were taken.

There was a decrease in the quality of the functional assessments and PBSPs.

Not all staff implementing PBSPs were trained on the implementation of that PBSP.

Outcome 1 – When needed, individuals have goals/objectives for psychological/behavioral health that are measurable and based upon assessments.											
Summary: El Paso SSLC continued to attend to PBSP data reliability. Due to sustained high performance over three consecutive reviews (all but one individual meeting criteria each review), indicator 5 will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
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.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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	1/1		1/1	0/1	1/1	1/1

Comments:
5. Individual #23, Individual #7, Individual #190, Individual #91, Individual #35, Individual #201, and Individual #119 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 #173's last IOA and DCT was more than six months ago (June 2021). Individual #30 did not have a PBSP.

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: For the seven (of eight) individuals for whom there were reliable PBSP data, three were making progress. For the other four, one or more aspects of behavioral health supports were not in place at criteria (i.e., other monitoring indicators). In some cases, when objectives were met, they were updated. Similarly, in some cases, when progress was not occurring, actions were taken. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
6	The individual is making expected progress	38% 3/8	1/1	0/1	0/1	0/1		1/1	0/1	0/1	1/1
7	If the goal/objective was met, the IDT updated or made new goals/objectives.	50% 1/2	0/1								1/1
8	If the individual was not making progress, worsening, and/or not stable, corrective actions were identified/suggested.	60% 3/5		0/1	0/1	1/1			1/1	1/1	
9	Activity and/or revisions to treatment were implemented.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									

Comments:
6. Individual #119, Individual #35, and Individual #23 had recent PBSP data that indicated that they were progressing.

7. Individual #119 achieved her SIB and physical aggression objectives in October 2021, and they were extended to February 2022. Individual #23's taking edibles and urinating outside objectives, however, were achieved in April 2021, but were not updated until July 2021.

8. Individual #201 was not making expected progress, however, her progress notes identified a referral to psychiatry to review her recent medication changes and a referral for a single room to address the lack of progress. Individual #173's progress note also indicated a lack of progress, and action documented was a review of his medications and level of supervision. Similarly, Individual #91's lack of progress resulted in staff being trained to more quickly respond to her requests for assistance.

Individual #190's progress notes, however, did not include any corrective actions to address his dramatic increase in physical aggression and restraints in September, October, and November 2021. Similarly, Individual #7's progress notes did not reflect any actions to address his increase in aggression in October and November 2021.

Ensuring that behavioral objective are updated and actions to address the absence of progress are documented should be a priority for the behavioral health department.

Outcome 3 - All individuals have current and complete behavioral and functional assessments.											
Summary: Performance was lower than at the last two reviews. Some components of the FA were missing or incorrect. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
11	The functional assessment is current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
12	The functional assessment is complete.	67% 4/6	0/1		1/1	1/1		1/1	1/1	0/1	

Comments:
Criteria for indicators 1-9 were met for Individual #119 and Individual #35. Therefore, the remainder of the indicators in psychology/behavioral health were not rated for them.

12. The identification of hypothesized antecedents and consequences of targeted behaviors is an important component of an effective functional assessment. Individual #190 and Individual #173's functional assessments were found to be particularly well written, with clear hypothesized antecedents and consequences based on the results of the direct and indirect assessments.

The antecedents in Individual #23's functional assessment, however, appeared to be precursors to his target behaviors (e.g., running toward individuals who have food or drink), rather antecedents to the target behavior (e.g., preferred food items left out). Similarly, the

majority of antecedents in Individual #201's functional assessment appeared to be precursors, and the consequence appeared to be programmed consequences (e.g., Individual #201 is blocked/restrained), rather than maintaining variables (e.g., staff attention).

Outcome 4 – All individuals have PBSPs that are current, complete, and implemented.											
Summary: Performance was lower on both indicators compared with the last review and both will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
13	There was documentation that the PBSP was implemented within 14 days of attaining all of the necessary consents/approval	67% 4/6	0/1		1/1	1/1		1/1	1/1	0/1	
14	The PBSP was current (within the past 12 months).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
15	The PBSP was complete, meeting all requirements for content and quality.	67% 4/6	1/1		1/1	0/1		1/1	1/1	0/1	

Comments:

13. Individual #23 and Individual #119's PBSPs did not contain an implementation date, so it was not possible to determine if the PBSP was implemented within 14 days of attaining necessary consents. Individual #201's PBSP appeared to be implemented prior to receiving necessary consents.

15. The Monitoring Team reviews 13 components in the evaluation of an effective positive behavior support plan (PBSP).

Individual #201's functional assessment indicated that the target behaviors were maintained primarily by automatic events, and secondarily by attention. The PBSP was consistent with this hypothesis. The PBSP, however, identified the function of Individual #201's aggression as negative reinforcement, which is not consistent with the replacement behavior, or the results of the functional assessment.

The Monitoring Team typically finds behavioral objectives (one of the necessary components of a PBSP) in the progress notes, functional assessment, and/or PBSP. No objectives for Individual #91's target behaviors were found in any of those locations.

Outcome 5 – All individuals have PBSPs that are developed and implemented by staff who are trained.											
Summary: Staff training on PBSPs continued to not meet criteria, for many consecutive reviews. Plans were written by credentialed professionals and if this maintains, this indicator might be moved to the category of requiring less oversight after the next review. Both indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119

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.	17% 1/6	1/1		0/1	0/1		0/1	0/1	0/1	
18	The individual's functional assessment and PBSP were written by a BCBA, or behavioral specialist currently enrolled in, or who has completed, BCBA coursework.	100% 6/6	1/1		1/1	1/1		1/1	1/1	1/1	

Comments:
16. Individual #23 was the only individual who had documentation that at least 80% of direct support professionals (DSPs) implementing his PBSP were trained on its implementation. Ensuring that all staff implementing PBSPs have been trained should be a priority for the Behavioral Health department.

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

Summary: Indicator 19 will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
19	The individual's progress note comments on the progress of the individual.	100% 6/6	1/1		1/1	1/1		1/1	1/1	1/1	
20	The graphs are useful for making data based treatment decisions.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
21	In the individual's clinical meetings, there is evidence that data were presented and reviewed to make treatment decisions.										

Comments:

Outcome 7 – Individuals who need counseling or psychotherapy receive therapy that is evidence- and data-based.

Summary: El Paso SSLC continued to try to obtain and provide counseling supports when identified as a need by the IDT. These indicators will remain in active monitoring.

#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
24	If the IDT determined that the individual needs counseling/ psychotherapy, he or she is receiving service.	50% 1/2		0/1	1/1						
25	If the individual is receiving counseling/ psychotherapy, he/she has a complete treatment plan and progress notes.	N/A									

Comments:
24. Individual #7 and Individual #190 were referred for counseling services. At the time of the remote review, Individual #190 was receiving counseling. Individual #7, however, had been referred since August 2021 and was not, as of the time of the remote review, receiving counseling service.

25. Counseling at El Paso SSLC was provided in the community and, therefore, this indicator was not scored.

Outcome 8 – Data are collected correctly and reliably.											
Summary: The Center scored higher than ever before on indicator 30. Continued high performance on this indicator might lead to it being moved to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
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.	83% 5/6	1/1		1/1	1/1		1/1	0/1	1/1	
Comments: 30. Goal frequencies and levels of DCT, IOA, and treatment integrity were achieved for Individual #23, Individual #7, Individual #190, Individual #91, and Individual #201. Goal frequencies were not achieved for Individual #173. This represents a substantial improvement from the last review when goal frequencies and levels of DCT, IOA, and treatment integrity were achieved for 57% of individuals.											

Section L: Medical Care

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Five of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

Annual medical assessments (AMA) were present, and about half were timely. Regarding interval medical reviews (IMR), none of the individuals had a full year's set of IMRs and some had no IMRs at all. It was difficult to use the IMRs to identify monitoring and changes in treatment for chronic diseases because there were either no IMRs or they did not contain enough detail to follow the course of the condition.

Annual medical assessments need to include, as applicable, family history, childhood illnesses, updated active problem lists, and thorough plans of care for each active medical problem.

None of the individuals received the full set of preventative care they needed. IDTs generally did not follow the process of meeting to review the risk-benefit of delaying preventative care.

Medical staff need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. Few of the IHCPs chronic or at-risk conditions included any action steps assigned to the PCPs.

It was good to see that for all individuals, medical practitioners had reviewed and addressed, the associated risks of the use of benzodiazepines, anticholinergics, and polypharmacy, and metabolic and endocrine risks.

All individuals had an assessment documented prior to hospitalization, ED visit, or infirmary admission. More work needs to be done to document the summary of events leading to hospitalization and IDT discussion regarding follow-up and actions to reduce risks.

PCPs were not always reviewing consultations in a timely manner. Documentation included all required components, but more work was needed to ensure that IDTs review all recommendations and develop a plan to address when necessary.

Outcome 2 – Individuals receive timely routine medical assessments and care.											
Summary: Annual medical assessments (AMA) were present, and about half were timely. Regarding interval medical reviews (IMR), none of the individuals had a full year's set of reviews and some had no interval reviews at all. It was difficult to use the IMRs to identify monitoring and changes in treatment for chronic diseases because there were either no IMRs or they did not contain enough detail to follow the course of the condition. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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, this indicator moved to the category requiring less oversight.									
b.	Individual has a timely annual medical assessment (AMA) that is completed within 365 days of prior annual assessment, and no older than 365 days.	56% 5/9	0/1	1/1	1/1	0/1	1/1	0/1	1/1	1/1	0/1
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. For four individuals, the PCPs did not complete AMAs within 365 days of the prior one.

c. Per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). This requirement was not meet for any of the individuals.

- For Individual #198, two of three required quarterly IMRs were submitted. Neither were timely.
- For Individual #118, Individual #161, Individual #115, Individual #13, and Individual #142, one IMR was submitted.
- For Individual #102, Individual #201, and Individual #162, none were submitted.

Outcome 3 – Individuals receive quality routine medical assessments and care.											
Summary: Moving forward, the Medical Department should focus on ensuring medical assessments include, as applicable, family history, childhood illnesses, updated active problem lists, and thorough plans of care for each active medical problem, when appropriate. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	Individual receives quality AMA.	44%	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1

		4/9									
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.	11% 2/18	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/2	0/2

Comments:
a. Four individuals had an AMA that included all the necessary components and addressed the selected chronic diagnoses or at-risk conditions with thorough plans of care. Those that met criteria were Individual #118, Individual #102, Individual #115, and Individual #13.

For the remaining five individuals, problems varied including:

- Individual #198's problem list did not include his hearing impairment and the results of audiology follow-up dated 2/19/21 were not included in the AMA. In 2019, his audiological exam noted new hearing aids. There was no follow-up notation to determine if he was able to use his hearing aids. There was no physician hearing screen. His neurological exam did not include reflexes. Triglycerides were increased because of medication and he was on treatment, however, there was no assessment of the efficacy of that treatment. This was true for most of the active problems, that is, that there was no assessment of stability or instability or improvement in the condition. Follow-up plans for psychiatry, dermatology, and infectious diseases were either not listed or were listed as "scheduled" or "recommended" rather than the next visit or the cadence of follow-up if the next visit was not scheduled.

- Individual #201's social history was present, but no childhood illnesses, prenatal, or smoking history was included. Understanding her hydrocephalous and how it occurred (congenital versus acquired) and any childhood conditions would be important. She had both a biologic father and aunt who were still in contact with her from which to get this history. A fundoscopic exam, if doable, would be a good baseline given the presence of a VP shunt in the case that the shunt begins to malfunction, the symptoms are non-specific, and the fundoscopic exam changes. There were more areas in the assessment and plan than on the problem list (e.g., pedal edema, osteopenia) and vice versa (e.g., psychosis, diabetes mellitus). The assessment and plan did not describe the issue to compare in the future (recognizing that this is a first assessment) and the follow-up plans did not list intervals, when pending consultations were to occur, how coordination with psychiatry would occur, or other details that would provide information about each of the conditions and what would next be expected for follow-up and treatment. Psychiatric diagnoses listed and clinical impressions on both MD description and observation were inconsistent.

- For Individual #162, the physical exam stated motor-hemiplegia, but in ambulation describes a diplegia. Reflexes, tone, and presence or absence of joint contractures are important to be consistent with the diagnosis of cerebral palsy and to document the baseline neurologic exam. Vision status was unclear. Cranial nerve II was intact, he had a cataract and an implanted lens in an eye that had microphthalmos with a coloboma. The hearing was the same situation in that the cranial nerve VIII was listed as intact, but he was described as having hearing loss. In general, the assessment contained information putting together the clinical picture, although in some cases, was not very detailed. As well, the plans generally included all aspects of care, but could use more detail about when the next consultation or lab test will be based on the previous one listed in the AMA with an approximate time frame (e.g., month and year) rather than at six months, or as recommended, which was not very informative.

- For Individual #161, family and childhood history were listed as unavailable and unknown, respectively, however, the ISP noted that the family attended the most recent ISP meeting, so that history should be able to be obtained. There was a social history present, but it did not describe the current family situation and referred only to her early history. There was nice detail in the assessments and plans for the most part, although some still lacked details of when test would be done (e.g., follow-up TSH and T4 after increase in thyroid medication).

- Individual #42's AMA included social history, but not family medical history. Her family was reportedly still in contact, and the family medical history could be updated as could what is known about childhood illnesses, if she had any. Allergies and severe drug reactions were missing from the AMA. Dietary allergies (none and lactose both were listed) were present, but no mention of allergies or reactions to medications. While assessment and plan were generally present there were some significant gaps in some of the problems. For example, for hypothyroidism, the assessment stated abnormal TSH and T4 values and the plan was to continue with the dose of thyroid medication. However, in the lab section, there were multiple thyroid testing results, and the dose of thyroid medication was increased earlier in the year with a normal value on follow-up. The assessment/plan should reflect what occurred over the year. Some plans were to do tests (e.g., ECHO and TSH) per policy, but no sense of what that was in this specific individual's case. The dose of allopurinol was decreased, but no justification for that. Other conditions did not have any description of current state or state across the year (e.g., constipation, onychomycosis, leukopenia).

c. 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 #198 – gastrointestinal problems and congenital HIV; Individual #201 – cardiac disease and weight; Individual # 118 – osteoporosis and weight; Individual #102 – cardiac disease and gastrointestinal problems; Individual #162 – osteoporosis and cardiac disease; Individual #161 – iron deficiency anemia and circulatory disease, and osteoporosis; Individual #115 – tremors and seizures; Individual #13 – gastrointestinal problems and seizures; Individual #42 – weight and seizures).

As noted above, none of the nine individuals had a full set of timely quarterly reviews. Two individuals, however, had a periodic medical review that met criteria for at least one risk area reviewed.

- Individual #198 had an IMR that addressed the clinical issue of congenital HIV, including testing and monitoring of his condition.
- Individual #201's completed IMR addressed her osteoporosis and followed the progress of her condition with treatment.

Outcome 4 – Individuals receive preventative care.	
Summary: None of the nine individuals received the full set of preventative care they needed. In addition, IDTs generally did not follow the process of meeting to review the risk-benefit of delaying preventative care. It was good to see that for all individuals, medical practitioners had 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. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	Individual receives timely preventative care:										
	i. Immunizations	44% 4/9	0/1	0/1	1/1	1/1	0/1	0/1	1/1	1/1	0/1
	ii. Colorectal cancer screening	40% 2/5				0/1	0/1	0/1	1/1		1/1
	iii. Breast cancer screening	50% 2/4		1/1	0/1			0/1			1/1
	iv. Vision screen	75% 6/8	1/1	0/1	Not rated CV19	0/1	1/1	1/1	1/1	1/1	1/1
	v. Hearing screen	67% 6/9	0/1	0/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1
	vi. Osteoporosis	88% 7/8		1/1	1/1	1/1	1/1	1/1	0/1	1/1	1/1
	vii. Cervical cancer screening	33% 1/3		0/1				1/1			0/1
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.	100% 9/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1

Comments:

a. One of the nine individuals received all the preventative care they needed. This was Individual #13. In one case, COVID-19 precautions appeared to be the cause for the delays in the provision of the care, but at times, delays were unrelated to the pandemic.

- For Individual #198, immunizations did not reflect current recommendations for pneumococcal immunizations, given his current medical conditions, including both the 13 and 23 valent vaccines. He had only had one. The required hearing screen was not indicated in the annual medical examination.
- For Individual #201, given her new diagnosis of cardiomyopathy, the pneumococcal vaccine 23 valent would be indicated. The consideration of HPV immunization, recommended for her age, was not documented. Her cervical cancer, vision, and hearing screens were not completed.
- For Individual #118, a previous breast exam in 2017 with ultrasound indicated the presence of masses. It was unclear what the masses were or what the appropriate follow-up should be, although regular breast cancer screening with mammography is not standard in this age group. Her ophthalmology annual exam was scheduled for 3/5/21. At that time, some appointments were being rescheduled because of Covid-19.
- Individual #102 had a polyp removed in 2009, then presented with rectal bleeding in 2014. At that time, another polyp was found during a colonoscopy. He was admitted to the hospital in November 2021 with a bowel obstruction and a polyp was

noted to be the cause. More frequent intervals for colonoscopy are generally recommended for those with polyps. Had that occurred, then he might not have developed a bowel obstruction. (Follow-up is recommended in four months because there is a 25 to 30% chance that there will be other polyps per https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7389642/.) He did have BMD screening in December 2021, however, the timeframe listed to follow-up was 2020 because his last measurement had been in 2018. Additionally, his last vision and hearing were completed in 2018.

- Individual 162's immunizations were complete, except for Hepatitis A, for which there was no evidence of receipt or discussion. Additionally, he was age 55 and there was no evidence that a colorectal screen had been completed.
- For Individual #161, there was no evidence of a varicella titer. ACIP recommends that all healthy adults without evidence of immunity should be immunized. While her age was indicative that she likely had the infection, there was no history of such under childhood illnesses, therefore, a titer and then vaccination would be recommended. There was also no evidence of discussion regarding Hepatitis A vaccination. A follow-up mammography was due in April 2021. There were no results available for review. There was also no evidence that a colorectal cancer screen was completed.
- For Individual #115, a previous DEXA scan was completed in 2015 with changes of 5 to 10% from the previous measure. Notes stated that the scan would be repeated, but no repeat scan was available. A hearing screen was completed, and hearing was noted to be "functional." A previous audiology exam completed in June 2016 noted probably moderate bilateral sensorineural hearing loss, as well as noting that hearing could not be tested. The inconsistency between the two exams was concerning.
- For Individual #42, missing vaccinations included Hepatitis A and a varicella titer, as there was not childhood history of chickenpox documented. Consideration for early administration (before age 65) of pneumococcal vaccine with 23 valent might be made given diagnosis of Trisomy 21 which is often associated with some degree of ineffective immune system. A cervical cancer screening was last completed in 2015, though recommended every three years.

b. For all individuals, 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.

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: One individual had a DNR in place that had not been reviewed or updated. This indicator will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 198	201	118	102	162	161	115	13	42
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.	0% 0/1							0/1		

Comments:
a. Individual #115 had an order for limited intervention that was dated 2018. There was no diagnosis identified that might support the need and no evidence that it had been reviewed since 2018.

Outcome 6 – Individuals displaying signs/symptoms of acute illness receive timely acute medical care.

Summary: All individuals had an assessment documented prior to hospitalization, ED visit, or infirmary admission. More work needs to be done to document the summary of events leading to hospitalization and IDT discussion regarding follow-up and supports to reduce risks, as appropriate. Overall, scores were about the same or slightly higher on these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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.	56% 10/18	1/2	0/2	0/2	2/2	2/2	2/2	1/2	2/2	0/2
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.	85% 12/14	2/2	1/2	1/1	2/2	1/1	1/1	2/2	0/1	2/2
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	0/1		0/1	2/2	1/1		0/1	1/1	
d.	As appropriate, prior to the hospitalization, ED visit, or Infirmary admission, the individual has a quality assessment documented in the IPN.	100% 6/6	1/1		1/1	2/2	1/1			1/1	
e.	Prior to the transfer to the hospital or ED, the individual receives timely treatment and/or interventions for the acute illness requiring out-of-home care.	67% 4/6			0/1	2/2	1/1		1/1	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 appropriate.	67% 6/9	1/1		0/1	1/2	1/1	1/1	1/1	0/1	1/1
h.	Upon the individual's return to the Facility, there is evidence the PCP conducted follow-up assessments and documentation at a frequency	100% 7/7	1/1		1/1	2/2	1/1		1/1	1/1	

	consistent with the individual's status and the presenting problem with documentation of resolution of acute illness.										

Comments:
For the nine individuals reviewed, the Monitoring Team reviewed 18 acute illnesses addressed at the Center:

- Individual #198 (facial injury on 9/13/21 and knee injury on 11/16/21),
- Individual #201 (ankle/foot injury on 6/16/21 and URI on 10/14/21),
- Individual #118 (small bowel obstruction on 6/29/21 and post-hospital pneumonia on 6/1/21),
- Individual #102 (bowel obstruction on 11/9/21 and UTI, pneumonia on 10/7/21),
- Individual #162 (pneumonia on 10/6/21, and G/J tube dislodgement on 11/18/21),
- Individual #161 (aspiration on 8/24/21 and bradycardia/ankle edema on 11/23/21),
- Individual #115 (UTI/pneumonia on 10/11/21 and cough/nasal congestion on 7/14/21),
- Individual #13 (paronychia on 12/6/21 and laceration to finger on 7/21/21), and
- Individual #42 (anorexia/constipation on 6/29/21 and fall from chair on 11/3/21).

a. For the following 10 of 18 acute issues, PCPs assessed them according to accepted clinical practice,

- Individual #198 – knee injury
- Individual #102 – bowel obstruction and UTI/pneumonia
- Individual # 162 – pneumonia and G-J tube dislodgement
- Individual #161 – aspiration and bradycardia
- Individual #13 - paronychia and finger laceration
- Individual #42 – anorexia/constipation

Regarding those that did not meet criteria:

- For Individual #198's facial injury, vital signs were missing blood pressure. Clinic visit occurred 18 hours after he was observed hitting his head on the fence. Examination did not test vision, palpate for crepitus or other signs of fracture, or describe if there was asymmetry, except that the bruising was on one side. History did not assess for evidence of headache or other symptoms. The individual did not meet the at-risk criteria for a head CT because the event had occurred almost a day prior without any sequalae noted.
- For Individual #201's foot/ankle injury, full vital signs were not documented. The assessment was not timely and did not include relevant history related to the injury.
- For Individual #201's URI, it was unclear if the individual was the historian.
- For Individual #118's small bowel obstruction, details of history missing included urine output and trouble related to feeds. It was unclear who the historian was for the report.
- For Individual #118's post hospital pneumonia, the source of information was not documented and there was not a focused physical examination that included documentation of all positive and negative findings.
- For Individual #115's pneumonia, only the post hospital note was available for this event.
- For individual #42, the history related to anorexia lacked sufficient detail to consider the pattern of the three complaints: anorexia, constipation, and genital scratching. The individual had anorexia and constipation, two symptoms of hypothyroidism

that she was known to have. As well, she had recent thyroid studies that were abnormal (6/15/21) and had her dose of thyroxine increased 6/24/21. Parenthetically, the blood test result was available 6/16/21, however, the order to increase the medication did not start until 6/24/2021 and there was no note indicating that this was reviewed and no mention in the AMA that this change occurred during the year. The impact of dose change typically is expected within two to three weeks after the dose change. The history did not discuss how long the symptoms were there. In addition, genital scratching was described and poor hygiene with fecal matter still present identified on examination. This was the likely cause of the itching, and the problem should have been addressed by improving hygiene rather than a genital culture that was likely only to show contamination especially given that there was no discharge on exam. Considering that the thyroid medication had just been increased and the symptoms were consistent with that with resolution expected in a week or two, watching and waiting with symptomatic treatment of the constipation rather than embarking on a huge workup without direction might have been a better approach.

- On 11/3/21, Individual #42 fell out of a recliner and hit her head. There was no documentation that she was seen by the PCP or sent to ED. A skull x-ray was ordered, but no evidence that the individual was seen by the PCP for a baseline neurological examination or to assess for signs of a skull fracture or more significant head injury from the fall.

b. There was evidence that the PCP conducted follow-up assessments and documentation, as necessary, until the problem was stabilized or resolved for 12 of 14 acute illnesses/injuries:

- Individual #198 (facial injury on 9/13/21 and knee injury on 11/16/21),
- Individual #201 (URI on 10/14/21),
- Individual #118 (post-hospital pneumonia on 6/1/21),
- Individual #102 (bowel obstruction on 11/9/21 and UTI, pneumonia on 10/7/21),
- Individual #162 (pneumonia on 10/6/21),
- Individual #161 (aspiration on 8/24/21),
- Individual #115 (UTI/pneumonia on 10/11/21 and cough/nasal congestion on 7/14/21),
- Individual #42 (anorexia/constipation and fall from chair on 11/3/21).

For two, problems were found:

- For Individual #201 (ankle/foot injury on 6/16/21), no follow-up examination was done, and follow-up was prn. There was no follow-up documented on the results of the ankle and foot x-ray.
- For Individual #13 (paronychia on 12/6/21), follow-up at the clinic was attempted, but he refused to attend. Practitioner talked staff through observation. However, while this is generally a minor issue, this is a paronychia that required I&D because it did not respond to conservative treatment, and it would be important for the practitioner to look at the finger even if it meant going to his home or some other less charged space than the clinic to do so.

c. Four of seven individuals received timely evaluation prior to transfer to ED or hospitalization.

- Individual #198 was sent to the ED to obtain a CT scan. The injury occurred 18 hours prior to being seen and sent to the ED for a CT scan.
- For Individual #118, on 6/1/21, there were multiple delays in getting in touch with the PCP. Nursing saw her at 3:00 am on 6/1/21 without concerns. Around 9:00 am, nursing began to try to contact PCP related to concerns about dehydration and vitals. She was unable to make contact until noon after several attempts. Her PCP ordered labs and x-rays and instructed to take

her to the clinic so she could see her. The testing results were documented in a note timed 16:23 (4:23 pm), she was then sent to ED. Total delay in getting care was around seven hours, which was too much time for someone with a bowel obstruction and dehydration with hypernatremia.

- For Individual #115, the nurse called the physician who sent the individual to the ED by ambulance. However, there was no physician note to that effect. There should have been a physician note documenting the conversation with the nurse, the scenario presented, and the reason for the decision to put oxygen on the individual and to send them to the ED by ambulance (as opposed to seeing them in clinic that day).

d. For all individuals, there was a quality assessment documented prior to hospitalization, when appropriate.

e. In four of six cases, the individual received timely treatment and /or interventions prior to transfer to the hospital or ED.

- For Individual #118, intervention included an increase of water by 10cc per hour. This was unlikely to make a significant difference in dehydration where her mouth and oral surfaces were described as dry, and her skin was sunken, which indicated 6 to 9% dehydration in tube feeding.
- For Individual #13's laceration, consideration for irrigation of the wound should have been made because the length of time to treatment in the ED was unknown, especially in light of the pandemic.

g. Six of nine individuals had a post-hospital ISPA that addressed follow-up medical, and healthcare supports to reduce risks, as appropriate. The following exceptions were noted:

- For Individual #118, her ISPA discussed T-shirts instead of binders for the g-tube, but did not address early detection of issues that would have been appropriate in this case because this was the second instance of this issue. Given that she has had a previous obstruction and surgical procedure, she was at higher risk for repeated small bowel obstructions.
- For Individual #102, there was no ISPA associated with the date of his ED visit.
- For Individual #13, there was no ISPA corresponding to this event. While the finger laceration was the focus of this, the way it was obtained was more concerning. No description of the behaviors, antecedents, or other aspects of the incident were available. That should have been reviewed to assess how it could have been prevented or managed with him so that he did not injure himself.

h. For all individuals, there was 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 upon return to the facility.

Outcome 8 – Individuals receive applicable medical assessments, tests, and evaluations relevant to their chronic and at-risk diagnoses.	
Summary: Medical Department staff continue to need to make significant improvements with regard to the assessment and planning for individuals' chronic and at-risk conditions. For five of the 18 chronic or at-risk conditions reviewed, PCPs had conducted medical assessment, tests, and evaluations consistent with current standards of care, and/or identified the necessary treatment(s),	Individuals:

interventions, and strategies, as appropriate. This was a slight increase from the previous round. This indicator will remain in active monitoring.											
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	Individual with chronic condition or individual who is at high or medium health risk has medical assessments, tests, and evaluations, consistent with current standards of care.	28% 5/18	1/2	1/2	0/2	0/2	0/2	0/2	1/2	1/2	1/2

Comments:
For nine individuals, two of their chronic and/or at-risk diagnoses were selected for review:

- Individual #198: gastrointestinal issues and infectious disease.
- Individual #201: cardiac disease and weight
- Individual #118: osteoporosis and weight
- Individual #102: cardiac disease and gastrointestinal issues
- Individual #162: osteoporosis and cardiac disease
- Individual #161: circulatory issues and anemia
- Individual #115: tremors and seizures
- Individual #13: gastrointestinal issues and seizures
- Individual #42: weight and seizures

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 PCPs identified the necessary treatment(s), interventions, and strategies, as appropriate:

- Individual #198 – infectious disease
- Individual #201 – cardiac disease
- Individual #115 – seizures
- Individual #13 – gastrointestinal issues
- Individual #42 - weight

Comments regarding those that did not meet criteria for this monitoring indicator:

- For Individual #198, risk associated with GI issues, an initial workup to rule out viral etc. causes was appropriate. However, once the determination was made that this was likely related to a drug, the discussion did not include the possible culprits. The individual was on several medications known to cause liver toxicity (found in the NIH DILI list) in addition to the Stribild. The GI consult indicated that it was the Stribild, but before the biopsy results returned, the PCP stopped the risperidone. There did not appear to be a rationale for doing that and it had never been part of the discussion. It may have been the right thing to do (as the LFTs seemed to be resolving), however, there was a lack of discussion or consideration of all the possibilities.

- For Individual #201, weight was noted to be an issue and the goal in the IHCP was to keep her weight within five pounds of her baseline. However, on admission she had a weight of 184 lb. with some documentation that her weight at some point when living in the community was 144 lb. Her weight had steadily increased and was 212 lb. at her cardiology visit a few months

after admission. Her diet was listed in one place as a diabetic diet and in another as a regular diet. Neither of these are likely to control this level of weight gain. She was on antipsychotic medication that can also increase weight gain and put her at risk for diabetes. The prescribed plan was not adequate to address the significant continued weight gain with the potential for developing full blown diabetes, metabolic syndrome, and obesity, along with wear and tear on joints eventually leading to arthritis and other long-term complications of significant obesity.

- For Individual #118, Prolia, vitamin D, and g-tube feeds with calcium were appropriate considerations for osteoporosis. In Fall 2020, however, she was identified as having a high level of alkaline phosphatase with normal other liver enzymes and a high parathormone level, both of which could be consistent with bone demineralization. Her calcium was normal, but on the low side. There was no evidence that this was followed-up on or repeated or that there was an endocrine consultation as discussed. The high PTH level in the presence of primary hyperparathyroidism could give an increased alkaline phosphatase and bone demineralization. In this case this question was asked, but not pursued and no repeat PTH was completed.

- Additionally, for Individual #118, the nursing flow sheets and IHCP noted in the osteoporosis section that her weight was around 55 lb. (under the upper set limit of 110 lb.). However, ideal body weight requires both an upper and a lower limit as it is not healthy to have a BMI or weight that is too low or one that is too high. The ideal weight was noted to be between 62 and 67. While the individual was in the hospital, she was also tube fed and so dependent on the amount of nutrition given. Using the low weight post hospital to calculate would have resulted in poor weight gain to get back to her pre-hospital weight.

- For Individual #102, IPNs for minor injuries (scratches, etc.) between 6/1/21 and 7/29/21 listed systolic blood pressures in the 130s to 140s without mention. An IPN dated 7/29/21 identified that his blood pressures had been elevated for most of the month (the only place that serial blood pressures were noted). The work-up at this point was appropriate because he had several risk factors for hypertension. However, the recommendations for treatment of hypertension even in older persons is to treat to keep the systolic blood pressure in the 125 to 130 range and diastolic under 80. The blood pressures were not addressed until they reached much higher readings despite having been seen multiple times. He had visits between, and the medication was increased. But at the 8/24/21 visit for a cough, his blood pressure was 164/89 and the plan was to continue the medication with no comment on the level of the BP. At subsequent sick visits, his blood pressure was controlled but dropped to 106/58 and then 100/73 without mention in the note. No additional mention of blood pressure or control occurred until 11/19/21 after discharge from the hospital where the hospital had changed his losartan for valsartan (which could have been a formulary issue) and added amlodipine. There also was no mention of follow-up of the work-up that was done on 7/29/21 to pull that together with the picture. One method to use multiple blood pressure measurements is to take 12 measurements across a month, some from am and some from pm, and average them. This blood pressure can be used to monitor treatment and provide a more global picture.

- Additionally, Individual #102 had a colonoscopy in 2009 with polyps that were removed. He had rectal bleeding in 2014 and on colonoscopy also had polyps that were removed. General recommendation for colon cancer screening for people with polyps, especially repeated ones, is to repeat the colonoscopy more frequently than every 10 years. There was no evidence that this was considered or that it was queried of the gastrointestinal consultant.

- Individual #162's first DEXA noted a BMD of T-2.4 in 2019 and a repeat in 2021 (two years later) showed a similar result T-2.3. He did get additional calcium during an observed medication pass, but neither vitamin D nor calcium were listed in either the pharmacy list or the AMA medication list prior to January 2022. It was not clear why treatment was delayed after the DEXA results were reviewed. Calcium and vitamin D supplementation plus weight bearing physical activity would be the appropriate treatments for osteopenia. As well, the PCP should review medications for those that might cause bone breakdown and consider if they are critical or could be replaced by something that has less of that effect.

- For Individual #162, there could be a number of causes of hypertriglyceridemia and while most of the lab evaluations were completed, it was not clear that they were looked at with this diagnosis in mind. As well, a review of medications is generally recommended to identify if any medications might be contributing to this. Treatment included low fat formula with a decrease in the triglycerides, but not to a normal value. There was no evidence of consideration of further treatment based on the risk of heart disease among other things. The IHCP included doing vital signs and O2 sats every shift as an intervention to address this, but that did not mitigate the risk. The recommended use of the gait trainer and physical activity may help lower the triglyceride levels, but there was no goal for amount of physical activity provided.

- Individual #161 was initially diagnosed with mild iron deficiency anemia and started on iron. She was also on vitamin B12 at the time, although the pattern did not fit vitamin B12 deficiency, and her level was high. Follow-up labs were completed in February 2021 with normal levels. The medication list in the AMA on 2/24/21 listed iron, but the pharmacy list did not and so it was discontinued appropriately at some point. Multiple CBCs were obtained with cell sizes just slightly larger than normal. It was noted that she was Vitamin B 12 deficient although her level was high, she was on vitamin B12. There was a note to consult hematology at her next visit about anemia (although she did not exhibit anemia at that point). Her hematology consult made no mention of anemia or the concern. Additionally, she had a hypercoagulable state with an IVC filter in place since about 2017 and treatment with Xarelto. A PT/INR was ordered. However, on Xarelto one would expect this to be abnormal and these are not used to monitor or change the drug dose. It was not a recommendation from the Hematology consultation.

- Individual #115's neurologic consult described a tremor. The IMR and AMA noted the tremor, as well. It was attributed to "general medical condition," but no consideration for possible causes, such as pulmonary medications or other medical causes. Treatment is not always needed, but some consideration of the potential underlying causes should have been addressed as well as the need to treat or not.

- Individual #13 was on two seizure medications one of which, phenytoin, had a subtherapeutic level. This medication had more likelihood of interacting with other medications and risks for side effects. There was no consideration for discontinuing it given that the level was not in the therapeutic range and the individual had not had any seizures. There were no discussions with neurology about consideration of discontinuation. In practice, preference is to treat with a single agent, if possible, control the seizures, and minimize side effects.

- Trisomy 21 puts Individual #42 at risk for dementia. Descriptions by some staff indicated that she was not functioning as well as she had previously. Her AMA noted to monitor for signs and symptoms of dementia, however, the concerns that were raised by other IDT members did not seem to have been communicated to her PCP.

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, overall, improvement was needed with regard to the inclusion of medical plans to address identified risks in individuals' ISPs/IHCPs. This indicator will continue in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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.	39% 7/18	1/2	1/2	1/2	0/2	0/2	1/2	1/2	1/2	1/2

Comments:

For the nine individuals, two of their chronic and/or at-risk diagnoses were selected for review:

- Individual #198: gastrointestinal issues and infectious disease.
- Individual #201: cardiac disease and weight
- Individual #118: osteoporosis and weight
- Individual #102: cardiac disease and gastrointestinal issues
- Individual #162: osteoporosis and cardiac disease
- Individual #161: circulatory issues and anemia
- Individual #115: tremors and seizures
- Individual #13: gastrointestinal issues and seizures
- Individual #42 weight and seizures

a. Seven of 18 ISPs/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.

Risk conditions that were not adequately addressed were:

- There was no IHCP addressing Individual #198's gastrointestinal issues even though it potentially could affect his behavior, medication choices, and other risks, as well.
- More intensive interventions were needed to address Individual #201's risk due to weight issues.
- Individual 118's risk of low weight included malnutrition, vitamin deficiencies, anemia, osteoporosis, frequent illness, and fatigue. Her weight from October 2020 before she was sick was 64 pounds, but her weight in Summer 2021 was 55 pounds. She was solely g-tube fed in Summer 2021 and her calories with 40cc of 1.5 cal/cc Levity per hour for 22 hours a day would give her around 1100 calories per day which is less than would be needed to maintain her weight at 55 pounds and not enough to get her back to her baseline weight of 64 pounds. This issue did not seem to be addressed.
- For Individual #102, the IHCP addressed the monitoring of vital signs which would include blood pressure and that of the electrolytes. Her risk for gastrointestinal issues was not considered in the IHCP.

- Individual #162's IHCP mentioned using the gait trainer to walk around her home for weight bearing to minimize her risk for osteoporosis, however, it did not include frequency or length of time that she should walk. To address her cardiac risk, her IHCP noted physician to monitor levels without indicating a frequency.
- For Individual #161, the IHCP did not mention anemia, but the condition was short-lived, and a goal may not have been appropriate given that it resolved quickly.
- Individual 115's IHCP did not address his tremors.
- For Individual #13, the IHCP listed only one anti-seizure agent, phenytoin. The phenytoin level was sub-therapeutic, which was not addressed. Further, carbamazepine is an anti-seizure medication as well and he was on both. Even though the carbamazepine was likely prescribed for psychiatric reasons it was still an anti-seizure medication.
- For Individual #42, her IHCP discussed seizures and monitoring for them, but there was no mention of the risk of developing dementia in this 49-year-old individual with Down syndrome. The average age of dementia starting in someone with Down syndrome is mid to late 40s and early 50s, so she was right in that period.

b. As noted above, per the instruction of State Office, and as memorialized in the State Office Medical Care policy #009.3, with an effective date of 2/29/20, PCPs now are expected to complete IMRs quarterly (i.e., any exceptions require Medical Director approval, and are limited to "very select individuals who are medically stable"). As a result, IHCPs no longer need to define the parameters for interval reviews, so the Monitoring Team did not rate this indicator.

Outcome 10 – Individuals' ISP plans addressing their at-risk conditions are implemented timely and completely.											
Summary: Two of the IHCPs for the chronic or at-risk conditions reviewed included any action steps assigned to the PCPs. This needs improvement. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	The individual's medical interventions assigned to the PCP are implemented thoroughly as evidenced by specific data reflective of the interventions.	19% 3/16	1/2	0/2	1/2	0/2	0/2	0/2	0/2	0/1	0/1

Comments:
a. This indicator was met for three of 16 risk conditions reviewed. IHCPs often did not include a full set of action steps to address individuals' medical needs. Rarely were action steps assigned to the PCP. This needs improvement.

- For Individual #198, the test to monitor viral levels and cell levels were all completed as was the follow-up with infection disease.
- For Individual #118, Prolia was given, she was on vitamin D, and a repeat DEXA was completed in August 2021.

Outcome 12 – Mortality reviews are conducted timely; however, there still needs to be a focus on recommendations and follow through.	
Summary: These indicators will continue in active monitoring.	Individuals:

#	Indicator	Overall Score	118	32							
a.	For an individual who has died, the clinical death review is completed within 21 days of the death unless the Facility Director approves an extension with justification, and the administrative death review is completed within 14 days of the clinical death review.	100% 2/2	1/1	1/1							
b.	Based on the findings of the death review(s), necessary clinical recommendations identify areas across disciplines that require improvement.	50% 1/2	0/1	1/1							
c.	Based on the findings of the death review(s), necessary training/education/in-service recommendations identify areas across disciplines that require improvement.	50% 1/2	0/1	1/1							
d.	Based on the findings of the death review(s), necessary administrative/documentation recommendations identify areas across disciplines that require improvement.	50% 1/2	0/1	1/1							
e.	Recommendations are followed through to closure.	0% 0/2	0/1	0/1							

Comments:
a. Two deaths were reviewed, Individual #118 and Individual #32. For both individuals, a clinical death review was completed timely.

b-d. For Individual #118, missing from the review was the interpretation of the vital signs and clinical picture when first encountered by the nurse. A respiratory rate and blood pressure should have been done, but putting the clinical picture together with hypothermia, tachycardia, and ashen appearance, she should have been transferred to the ER at that point with possible aspiration, possible sepsis and not have waited for almost two hours. The nursing review identified that emergency medical services should have been initiated in a timely manner when vital signs were critical, however, there were no specific recommendations to address this finding.

Recommendations included training for nursing and habilitation staff on acute respiratory failure, positioning following emesis, and oral care.

For Individual #32, the review indicated a failure to communicate risks, such as the risk for falls, to the hospital or to the DSP that was at the hospital with the individual (particularly when that staff may not be as familiar with the individual).

Habilitation recommendations included: (1) post-fall protocols typically indicate that a patient should not be moved until assessed for safety, if no post fall protocol is available, one should be developed to address need for assessment prior to assisting someone from the floor and (2) familiar staff should be assigned to individuals who are at high risk for falls, choking, aspiration.

e. For Individual #118, the Center did not submit full documentation to validate completion of all recommendations. For Individual #32, the Center did not submit a plan with selected recommendations for implementation, nor full documentation to validate completion of preliminary recommendations. Recommendations included nursing staff will be retrained on plan of care follow through and resolution. Status indicated training was pending.

Section M: Nursing Care

<u>Substantial Compliance – Exited Status</u>

None of the provisions of this section have met and achieved substantial compliance.

<u>Sustained High Performance – Less Oversight Status</u>

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, three additional indicators were moved to this category.

<u>Section Summary</u>
In general, acute illnesses were assessed, but acute care plans were not adequate and only some were implemented as designed.

New admission and annual nursing assessments were conducted timely. This has been the case for a number of consecutive reviews.

El Paso SSLC nursing assessments did not contain the required content as per nursing guidelines and did not adequately address each individual's at-risk conditions.

ISPs and their IHCP components did not address health risks and chronic conditions. Less than half of the risk areas had action steps, clinical indicators, and monitoring protocols.

Half to about two-thirds of action plans were implemented timely and thoroughly.

Many aspects in the administration of medications by nurses showed improvement and/or sustained high performance.

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: With the exception of indicator e, the other indicators scored higher than at the last review. In general, acute illnesses were assessed, but acute care plans were not adequate and only some were implemented as designed. These indicators will remain in active monitoring.	Individuals:

#	Indicator	Overall Score	198	201	102	118	115	162			
a.	If the individual displays signs and symptoms of an acute illness and/or acute occurrence, nursing assessments (physical assessments) are performed.	83% 5/6	1/1	1/1	1/1	1/1	1/1	0/1			
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.	100% 5/5		1/1	1/1	1/1	1/1	1/1			
c.	For an individual with an acute illness/occurrence that is treated at the Facility, licensed nursing staff conduct ongoing nursing assessments.	75% 3/4		0/1	1/1	1/1		1/1			
d.	For an individual with an acute illness/occurrence that requires hospitalization or ED visit, licensed nursing staff conduct pre- and post-hospitalization assessments.	100% 3/3	1/1		1/1		1/1				
e.	The individual has an acute care plan that meets his/her needs.	0% 0/4	0/1	0/1		0/1	0/1				
f.	The individual's acute care plan is implemented.	40% 2/5	0/1	0/1	1/1	1/1	0/1				

Comments:
The Monitoring Team reviewed six acute illnesses and/or acute occurrences for six individuals, including Individual #198 –S/P liver biopsy, Individual #201-symptoms of infection, Individual # 102-GI, Individual #118-Skin Breakdown, Individual #115-Pneumonia, and Individual #162-Seizures.

a. The acute illnesses/occurrences for which initial nursing assessments (physical assessments) were performed were in accordance with applicable nursing guidelines were for Individual #198, Individual #201, Individual #102, Individual #118, and Individual #115.

For Individual #162, on 6/23/21, IPN and IView notes indicated that the individual's mom, who was visiting him, reported to the nurse that he had two small seizures, involving tongue side to side movements, and head rolling for a few seconds. The nurse responded efficiently to the reported s/s and performed assessment, during which the mom asked if he could have his anti-epileptic drugs right away. The nurse provided education on medications and that he would receive prescribed meds soon, within the ordered times. It was positive that the nurse quickly assessed the individual, performed vital signs, lung sounds, and SpO2 readings, which were normal, however, the assessment did not include sensorium, PERRLA, and pupils for neuro-assessment.

b. All the applicable individuals that had an acute illnesses/occurrences had their licensed nursing staff timely inform the practitioner/physician of signs/symptoms in accordance with the SSLC nursing protocol.

c. through e. The following provides some examples of findings related to this outcome:

- For Individual #198, the ACP did not include when to change the dressing (usually after 24-48 hours). There was no IPN documentation of when dressing was removed, nor a nursing description of biopsy assessment/skin upon the dressing being removed.
- For Individual #201, there was noted inconsistency in the scope and implementation of the ACP. The complaint of ear pain was documented on 10/14/21, however, it was not identified as an acute issue requiring interventions until the ACP was opened on 11/8/21. Nursing diagnosis was deemed as an "Alteration in Comfort" due to otitis and breathing treatment, however, according to the note 11/8/21 at 1457, the ACP was validated by RNCM due to otitis media being treated with Doxycycline. The follow-up interventions, and documentation of the plan and assessments were inconsistent in scope, for example, ear drops were mentioned in two of the 10 notes, and appearance of ear swelling also only mentioned in one of the 10 nursing notes. Bronchitis was noted once as the condition being treated by the ABTX, and there were several notes that did include information about nebulizer treatments.
- Individual #102 was being monitored with VS QS as part of the chronic and existing Nursing Care Plan. Nursing IPNs, and IView assessments leading up to the acute change event indicated that nurses increased the frequency of the assessments when symptoms were starting, which enabled them to catch the abnormal Pulse, O2 sats, and changes of blood pressure, respiratory, and GI. Nursing interventions were appropriate and well documented.
- For Individual #118, while the desired outcome of visible improvement was accomplished, and the nursing IPNs and IView provided evidence of skin assessment, as well as providing skin care barrier crème, the ACP was lacking measurable clinically relevant indicators to display efficacy of interventions. The frequency of monitoring was also not clear. There were inconsistencies with the resulting nursing IPNs and the majority did not include wound measurements.
- Individual #115 had a CP for Alteration in Comfort r/t hospitalization AEB displayed fatigue and weakness. Outcome was that the individual will be able to maintain comfort AEB 0 pain and return to normal level of activities. All assessments and interventions were to be documented in IView and Nursing Progress notes. The ACP was lacking measurable clinically relevant indicators to display efficacy of interventions, such as parameters of VS readings specific to individual, respiratory following a PNA, and urinary output related to UTI.

f: Issues with ongoing monitoring and follow through were the primary issues noted with acute care implementation for three of the individuals. For example:

- For Individual #198, following the implementation of the ACP on 10/27/21, IPN and IView documentation displayed varying levels of nursing assessment through 10/29/21 (three days rather than the five days as indicated in the ACP). There was no documented follow-up to indicate that RN had determined to end the ACP at that point, nor to clinically support that rationale.
- For Individual #201, the Monitoring Team was unable to locate a summary note to close the ACP as is required per the Nursing Guideline.
- For Individual #115, the follow-up interventions, and documentation of the plan were inconsistent. For example, 10/16/21 2105 was the only Nursing Progress note for that day, there were no Nursing Progress notes found on 10/17/21, there were two Nursing Progress notes on 10/18/21 (the last one being to close ACP indicating he had improved, was comfortable, and was not in pain). IView documentation evidenced that the nurses were taking VS QS, although not all included lung/respiratory assessment.

Other positives included:

- For Individual #118, the IPNs showed a gradual shift in late July and early August 2021 from no worse to improvement and, eventually, the ACP was closed on 8/11/21 as resolved.
- Prior to a hospitalization/ED visit and upon the individual's return to the Center, the individual had a nursing assessment in alignment with nursing protocols as dictated by the individual's signs and symptoms.

Outcome 3 – Individuals have timely nursing assessments to inform care planning.											
Summary: New admission and annual nursing assessments were conducted timely. This has been the case for a number of consecutive reviews and, therefore, indicators a.i and a.ii will be returned to the category of requiring less oversight. Indicator a.iii will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	102	118	115	162			
a	Individuals have timely nursing assessments:										
	i. If the individual is newly-admitted, an admission comprehensive nursing review and physical assessment is completed within 30 days of admission.	100% 1/1		1/1							
	ii. For an individual's annual ISP, an annual comprehensive nursing review and physical assessment is completed at least 10 days prior to the ISP meeting.	100% 5/5	1/1		1/1	1/1	1/1	1/1			
	iii. Individual has quarterly nursing record reviews and physical assessments completed by the last day of the months in which the quarterlies are due.	60% 3/5	0/1	0/1	1/1	1/1	1/1	1/1			

Comments:

a.i. and a.ii. All the applicable individuals reviewed had timely annual comprehensive nursing reviews and physical assessments.

a.iii. Regarding quarterly nursing record reviews and physical assessments:

- For Individual #198, the Registered Nurse Case Manager (RNCM) completed two quarterly nursing record reviews in October 2021, although on 5/12/21, the RNCM completed a physical evaluation, the corresponding record review was dated 10/13/21.
- For Individual #201, the Registered Nurse Case Manager (RNCM) completed two quarterly nursing record reviews in December 2021, although on 5/4/21, the RNCM completed a physical evaluation, the corresponding record review was dated 12/16/21.

Outcome 4 – Individuals have quality nursing assessments to inform care planning.											
Summary: The scoring and comments show that El Paso SSLC nursing assessments did not contain the required content as per nursing guidelines and did not adequately address each individual's at-risk conditions. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	102	118	115	162			
a.	Individual receives a quality annual nursing record review.	50% 3/6	1/1	0/1	1/1	1/1	0/1	0/1			
b.	Individual receives quality annual nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	33% 2/6	0/1	1/1	0/1	0/1	0/1	1/1			
c.	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% 0/12	0/2	0/2	0/2	0/2	0/2	1/2			
d.	Individual receives a quality quarterly nursing record review.	33% 2/6	0/1	1/1	1/1	0/1	0/1	0/1			
e.	Individual receives quality quarterly nursing physical assessment, including, as applicable to the individual: i. Review of each body system; ii. Braden scale score; iii. Weight; iv. Fall risk score; v. Vital signs; vi. Pain; and vii. Follow-up for abnormal physical findings.	0% 0/6	0/1	0/1	0/1	0/1	0/1	0/1			
f.	On a quarterly basis, nursing assessments completed to address the individual's at-risk conditions are sufficient to assist the team in maintaining a plan responsive to the level of risk.	0% 0/12	0/2	0/2	0/2	0/2	0/2	0/2			

g.	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.	50% 5/10	N/A	0/2	2/2	1/2	1/2	1/2			

Comments:

a. Individual #201, Individual #115, and Individual #162 did not receive a quality annual nursing record review due to components not being fully addressed. Issues noted included leaving the procedure history and family history sections blank

b. One-third of the individuals had nursing assessments completed that addressed their At-Risk conditions. The pervasive issue across the four assessments that did not meet criteria were the lack of comprehensiveness of the physical exam. Often missing from the exam was assessment of the individual's weight, abdomen, or bowel sounds.

c. Regarding annual nursing assessments:

- The nursing assessments included updates of the individual's current medical and behavioral/mental health risks, however, the documentation did not contain evidence of analysis of the data collected or comparisons to the previous quarter or year. The nursing assessment of risks did contain recommendations regarding treatment and interventions, but without the analysis, there were few to no individualized or new strategies included to display outcome of amelioration of the at-risk condition to the extent possible.
- For Individual #201, the assessment lacked historical information to provide proper analysis of the at-risk conditions.

d. One-third of the individuals received a quality quarterly nursing record review. Quality reviews were noted for Individual #201 and Individual #102.

- For Individual #198, issues were noted with the diagnoses list because the new diagnosis of Drug Induced Hepatitis was not found on the active problem/diagnoses lists. His procedure history was not updated to contain information regarding his liver biopsy, and his medications were not updated.
- For Individual #118, procedure history was not updated with recent GI surgery/GJ tube placement.
- For Individual #115, components absent from the review included family and procedure history.
- For Individual #162, components absent from the review included procedure history and tertiary care.

e. None of the individuals received a quality quarterly nursing physical assessment as applicable. Issues noted included absence of weight as well as other areas, such as abdominal circumference and bowel sounds.

f. None of the quarterly nursing assessments addressed the individual's at-risk conditions in a manner sufficient to assist the team in maintaining a plan responsive to the level of risk.

- Similar to the annual assessments, the quarterly nursing assessments did include updates of the individual's current medical and behavioral/mental health risks, however, the documentation did not contain evidence of analysis of the data collected or comparisons to the previous quarter or year. The nursing assessment of risks contained recommendations regarding treatment and interventions, but without the analysis, there were few to no individualized or new strategies included to display outcome of amelioration of the at-risk condition to the extent possible.

g. For five of 10 risks, if the individual had a change in status that required a nursing assessment, a nursing assessment was completed in accordance with nursing protocols or current standards of practice.

- For Individual #201 (weight and edema), her weight chart indicated a clinical change: increase from 197 lbs. on 6/27/21 to 204 lbs. on 7/3/21 (+7 lbs.). There was no evidence that a nursing assessment for edema was completed in IPNs or IView. There was no documented nursing assessment for lower extremity edema, and no notification of the MD found in the IPNs. The RNCM did notify the IDT and a PNMT referral was initiated

- For Individual #118 (respiratory compromise), nursing documentation reflected proper interventions and care. On 7/2/21 1445, the DSP notified nurse of lethargy, drooping arms, and not at her baseline. The nurse assessed at 1450 and noted that the individual became more alert, and was moving her arms. The nurse referred her to the MD who ordered labs for 7/3/21. Nursing continued to monitor vital signs and administer antibiotics through 7/5/21 as ordered. Notes indicated UA was negative for UTI, and she returned to baseline status. On 7/8/21 her repeat CXR showed the PNA that she had developed while hospitalized, was resolved.

- For Individual #118 (weight), the weight flow trending chart indicated a loss of 4.54% from 7/10/21 to 8/21/21, however, the comprehensive nursing quarterly assessment 8/31/21 summary/recommendations did not include an increase of frequency of the monitoring weights. The assessment stated, "weekly weights" and listed the weights from 5/26/21-8/28/21. This was in conflict to the PNMT IPNs which indicated that the IDT met on 7/9/21 and agreed to increase weights to twice weekly. Due to the fragility of the individual, recent medical history, including tube replacement, PNA, bowel obstruction, and returning to the facility with impaired skin issues the interventions and IDT action were not sufficient in reaching improvement.

- For Individual #115 (aspiration), his nursing progress note dated 10/19/21 at 1002 am summarized that earlier that morning at 0825, the DSP notified the nurse that the individual had a total of four emesis episodes at 0817, two at 0818 and at 0820. The individual was seen by the PCP and transferred to the ED at 0915 for possible aspiration and/or bowel obstruction. The nursing assessment(s) indicated that the nurse did document assessment of the abdomen and bowel sounds, but did not document assessment of lung sounds, even with a low SpO2 reading at 0843, nor was there a description of the material from emesis (e.g., if it contained any signs of bleeding).

- For Individual #162 (GI), IPN dated 11/18/21 at 1651, indicated LVN notified RN Supervisor at 1450 that G/J tube was dislodged. The RN assessed that the G/J tube was pulled out about three cm and the balloon was torn and deflated, however, the individual showed no s/s distress. Scant dark brown drainage was then noted on dressing with mild redness to stoma. His abdomen was soft, non-tender. The RN notified clinic nurse, and arranged transport by Life Ambulance to the ED, Vital signs/further clinical assessment was not evident as the last set of VS were documented 11/18/21 at 0650, approximately eight hours before the tube was noted as dislodged.

Outcome 5 – Individuals' ISPs clearly and comprehensively set forth plans to address their existing conditions, including at-risk conditions, and are modified as necessary.												
Summary: ISPs and their IHCP components did not meet criteria with these indicators to address health risks and chronic conditions. Less than half of the risk areas had action steps, clinical indicators, and monitoring protocols. These indicators will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	198	201	102	118	115	162				
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% 0/12	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% 0/12	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% 0/12	0/2	0/2	0/2	0/2	0/2	0/2				
d.	The IHCP action steps support the goal/objective.	33% 4/12	0/2	2/2	0/2	0/2	2/2	0/2				
e.	The individual's ISP/IHCP identifies and supports the specific clinical indicators to be monitored (e.g., oxygen saturation measurements).	42% 5/12	0/2	1/2	0/2	2/2	1/2	1/2				
f.	The individual's ISP/IHCP identifies the frequency of monitoring/review of progress.	17% 2/12	0/2	0/2	0/2	0/2	1/2	1/2				

Comments:

a-b. While all the individuals had IHCPs in place, none of the IHCPs sufficiently addressed the health risks and needs in accordance with applicable SSLC nursing protocols or current standards of practice. They did not include preventative approaches to minimize the at-risk conditions.

c. None of the IHCPs included measurable objectives to fully address the at-risk condition and to allow the team to track progress in achieving the plan's goals.

d. One-third of the IHCP nursing action steps supported the goals/objectives.

e. Less than half of the IHCP interventions included specific clinical indicators to be monitored.

f. Few of the IHCP interventions included frequency of monitoring/review of progress.

Comments for this outcome:

- For Individual #198, the IHCP for Infection/Skin was lacking measurable objectives to address the at-risk condition and allow the IDT to track progress, was lacking clinical indicators to be monitored, and had no plan for frequency of monitoring progress. The individual had a pattern of injuries/breaks in skin, relating to his behavior, as well as communication challenges due to deafness, placing him at risk for infection from injuries that staff may not even have been aware of. In addition, he did not always take his medications, which is crucial for antiviral therapy. Neither of these individualized concerns were included in the IHCP.

- For Individual #198, his IHCP for GI was not sufficiently updated to address his health risks and needs. Concerns with lab findings related to high liver enzymes began in Q2, however, the GI Risk Level was not increased from Medium to High until (Q4) 12/19/21. Therefore, no new nursing interventions were provided. While it was positive that an ACP was initiated by RNCM relating to liver biopsy procedure with sedation at UMC on 10/27/21, the IHCP did not include individualized specific interventions, such as monitoring for signs of jaundice, characteristics of stool, and urine that staff should report. All of which should have been considered for implementation prior to the biopsy, when liver enzymes were increasing.

- For Individual #201, regarding her IHCP for Circulatory/Edema, while it was positive to see specific interventions for taking vital signs with cardiac medications and to report any abnormal rate/rhythm, the frequency and duration were vague for elevation of legs/feet when resting or sitting, making it difficult to implement and did not include how to properly measure progress. Intervention should include more specific instructions, individualized for her needs, and how to promote compliance.

- For Individual #201's IHCP for weight, objectives were related to weight gain, and interventions took into consideration a cross reference to circulatory risk edema, however, the interventions were not sufficient in outlining clear interventions. They did not include details as to frequency. For instance, "encourage daily walks to aid in decreasing weight" needed more specific information to guide staff in implementing, did not include where to document, nor a frequency measurement, such as "walk with staff for 10 minutes 3 x a day." It also lacked individualized approaches. "Provide current diet as per dietary/MD recommendations" did not include nursing interventions to address specific food choices or a way to offer alternative healthier foods/snacks.

- Individual #102's IHCP for Skin/Infections did specify stoma care BID and that vital signs will be taken every shift. However, there were no parameters as to what changes to report. IHCP lacked individualized preventative interventions, for example, the individual scratched his skin in past fungal infections, so the nurse should consider including ways to reduce the risk (e.g., keeping his nails short, assisting him to wash his hands every shift). Nutrition and fluid are also crucial in addressing skin integrity and preventing UTI, but those factors were not included. In addition, the IHCP did not include frequency of monitoring/review of progress.

- Individual #102's IHCP for GI displayed some components to reduce risks to the individual, however, it still required further details, such as review of BM to (Bristol) stool chart QS by the nurse, how much extra fluid to provide as tolerated, and how often and details of intervention encouraging exercise (other than just "when possible") to guide the staff in appropriately

providing the interventions. Nursing assessment should include auscultation of bowel sounds, including frequency. The frequency of monitoring/review of progress of the interventions was not specified.

- For Individual #118's IHCP for Respiratory Compromise, the IDT met on 6/29/21 and noted that RN will update the IHCP (post PNA). The IHCP did indicate review and update of other sections of the IHCP, but documentation did not reflect any related updates to Aspiration/Respiratory interventions by nursing, such as more frequent respiratory assessment/lung sounds/SP02.

- For Individual #118's IHCP Weight, frequency of monitoring weights was not increased when individual weight dropped during Q's. Actions other than just weight monitoring were not found in nursing interventions.

- For Individual #115's IHCP for Aspiration/Respiratory, nursing interventions included a full set of VS q shift documented in IView, NPO status, lung sound assessment q shift and PRN, baseline lung sounds monthly, refer to guidelines for respiratory distress/aspiration, oxygen use as ordered by PCP, LVN alert RN for adventitious breath sounds, administer nebulizer meds as ordered PCP. However, there were no preventative, individualized interventions to address excessive drooling/sialorrhea, or to address specific approaches and strategies to follow when he did not wish to use oxygen cannula/mask. Also lacking were specific parameters and signs and symptoms of hypoxia/oxygen saturations. As mentioned in the IRRF, slight discoloration to hands was a symptom noticed in the past requiring immediate attention. Frequency and method to monitor the progress were not found.

- For Individual #115's IHCP for GI, nursing interventions included to notify PCP for G/J tube dislodgements/malfunction immediately, NPO status, perform stoma care as ordered by PCP, ensure proper upright position/HOBE, ensure tube placement/auscultation, aspiration prior to g-tube use, do not aspirate contents of J tube, refer to guidelines for N/V/D/abdominal distention/pain, review bowel record daily, refer to guidelines for enteral feedings, instruct staff to offer the toilet often to encourage regular elimination, administer meds per PCP, and refer to PNMP for GERD precautions. However, nursing IHCP did not address abdominal binder application and precautions and did not include angle/measurements for proper upright position. Frequency of interventions were not well defined for "offering toilet often" and "review bowel record daily" and needed to be more specific to intervene/measure and monitor progress.

- Individual #162's IHCP for aspiration had components, including evidence of nursing implementation training to residential staff, and the importance of proper positioning, the interventions did not include a frequency of lung sounds assessment other than "monthly," which may not be sufficient to address individual's health risk. No measurement of SPO2 % was included, nor were there other potential signs/symptoms of aspiration included (e.g., full VS including temperature).

- Individual #162's IHCP for GI had appropriate nursing interventions relating to G/J tube dislodgement with a desired outcome of no dislodges in the next three months. The IHCP nursing interventions did include how to measure outcomes related to avoiding dislodgement of the tube, however, the high-risk GI IHCP did not include interventions related to prevention of constipation or a GI assessment.

Outcome 6 – Individuals' ISP action plans to address their existing conditions, including at-risk conditions, are implemented timely and thoroughly.

Summary: Half to about two-thirds of action plans were implemented timely and thoroughly. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	198	201	102	118	115	162			
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	58% 7/12	0/2	0/2	2/2	1/2	2/2	2/2			
b.	When the risk to the individual warranted, there is evidence the team took immediate action.	70% 7/10		0/2	2/2	1/2	2/2	2/2			
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).	50% 6/12	0/2	0/2	1/2	1/2	2/2	2/2			
d.	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 of the interventions as specified in the IHCP (e.g., trigger sheets, flow sheets).	88% 7/8			2/2	2/2	2/2	1/2			

Comments:
a.-c. As noted above in Outcome 4 indicator b (and not repeated here), there was a lack of assessment provided in response to changes in status. This lack of assessment impacted the Center's ability to implement the needed supports and interventions in a timely manner for those individuals and risk areas that did not meet criteria with these monitoring indicators.

d. Most of the individuals at a high risk for respiratory issues and/or pneumonia had evidence of the nurse documenting the frequency of lung sounds. The exception was for Individual #162.

Outcome 7 – Individuals receive medications prescribed in a safe manner.

Summary: Many aspects of this outcome showed improvement and/or sustained high performance. For instance, sustained high performance regarding the following of the PNMP resulted in indicator f being moved to the category of requiring less oversight. The other indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	161	42	115	102	201	13	162	198	118
a.	Individual receives prescribed medications in accordance with applicable standards of care.	Not scored									

b.	Medications that are not administered or the individual does not accept are explained.	Not scored									
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).	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
d.	In order to ensure nurses administer medications safely: For individuals who exhibit signs and symptoms of respiratory issues and/or aspiration during medication administration, the nurse will immediately stop the medication administration and complete an assessment which will include lung sounds and may include a full set of vital signs, pulse oximetry, etc. as indicated at the time of the assessment.	N/A									
e.	If the individual receives pro re nata (PRN, or as needed)/STAT medication or one time dose, documentation indicates its use, including individual's response.	100% 2/2	1/1							1/1	
f.	Individual's PNMP plan is followed during medication administration.	100% 4/4	1/1		1/1		1/1		1/1		
g.	Infection Control Practices are followed before, during, and after the administration of the individual's medications.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
h.	Instructions are provided to the individual and staff regarding new orders or when orders change.	0% 0/2					0/1			0/1	
i.	When a new medication is initiated, when there is a change in dosage, and after discontinuing a medication, documentation shows the individual is monitored for possible adverse drug reactions.	N/A									
j.	If an ADR occurs, the individual's reactions are reported in the IPNs.	N/A									
k.	If an ADR occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	N/A									
l.	If the individual is subject to a medication variance, there is proper reporting of the variance.	100% 6/6	1/1		1/1	1/1	1/1		1/1		1/1
m.	If a medication variance occurs, documentation shows that orders/instructions are followed, and any untoward change in status is immediately reported to the practitioner/physician.	100% 1/1								1/1	
	Comments:										

The Monitoring Team conducted observations of eight individuals: Individual #161, Individual #42, Individual #115, Individual #102, Individual #201, Individual #13, Individual #162, and Individual #198.

a-b. The Monitor continued to work with State Office on a method for the Monitoring Team to have access to readable formats of MARs for the monitoring review period.

e. It was positive that when applicable, individual received pro re nata/STAT medication with documentation indicating its use, and including individual's response.

f. PNMPs were followed during all medication observations. These is an area that has shown improvement.

h. For two individuals, instructions were not provided to the individual and staff regarding new orders or when orders change

- For Individual #201 there was no documented instruction/teaching to the individual related to increase of furosemide from 20 mg to 40 mg on 8/10/21.
- Per IDT notes 11/3/21 risperidone for behavior was discontinued on 10/28/21 due to high liver enzymes. IDT was unaware prior.

l. There were six individuals that had documented medication variance(s). It was positive to see that all were subjected to a medication variance review, meaning that there was reporting of the variance, Most of the missing doses were discovered during routine bin counts in the medication room, and there were notes regarding the plan to re-educate nursing staff.

Section N: Pharmacy Services and Safe Medication Practices

Substantial Compliance – Exited Status

Six of the provisions of this section have met and achieved substantial compliance: N1, N2, N3, N4, N5, N7.

Thus, the corresponding 14 monitoring indicators are no longer monitored or scored: N1a-b, N2a-e, N4a-b.

Sustained High Performance – Less Oversight Status

One of the monitoring indicators of this section was in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

Section Summary
For the one ADR identified, some gaps in clinical follow-up remained, including a thorough discussion by the Pharmacy and Therapeutics Committee.

Outcome 3 – When individuals experience Adverse Drug Reactions (ADRs), they are identified, reviewed, and appropriate follow-up occurs.											
Summary: Indicator b had been returned to active monitoring after the last review. For the one ADR identified, some gaps in clinical follow-up remained, including a thorough discussion by the Pharmacy and Therapeutics Committee. Indicators b and c will remain in active monitoring. Given high performance during reviews when applicable, indicator d will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	ADRs are reported immediately.										
b.	Clinical follow-up action is completed, as necessary, with the individual.	0% 0/1	0 /1								
c.	The Pharmacy and Therapeutics Committee thoroughly discusses the ADR.	Not rated	Not rated								
d.	Reportable ADRs are sent to MedWatch.	100% 1/1	1/1								

Comments:
b-d. For individual #198, a possible ADR was noted 9/21/21 and reported 10/5/21. The first set of abnormal liver function tests were in August with 8/3/21 being somewhat elevated and 8/31/2021 even more elevated. Although at that time, it may not have been

suspected or determined that the cause of the elevated liver function tests was drug induced because all of the work-up had not been completed.

A pharmacy assessment was completed 10/25/21. Literature review identified only a few case studies of risperidone causing liver function abnormalities. Weakness in review was that the pharmacist only looked at the drug that the PCP thought was the culprit (risperidone)and not other medications (Stibild®, naltrexone, omega-3, and/or Tylenol). Although, not considered at the pharmacy assessment, at a later GI consult on 11/3/21, Stibild® was identified as a possible cause if LFTs did not normalize with the discontinuation of risperidone. The individual was on several medications that were on the NIH list for risk of drug induced liver injury.

At the time of the review, the ADR had not been reviewed and finalized by the P&T committee. Following review of the draft report, the State office reported that the ADR was closed out after the remote review at the P&T committee meeting on 1/26/22.

Section O: Minimum Common Elements of Physical and Nutritional Management

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

None of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one indicator was moved to this category.

Section Summary

When individuals needed to be referred to PNMT, they were referred as per Center protocols. This has been the case for all individuals for more than three consecutive reviews, with an exception in Round 16 and one exception this round.

In general, PNMT assessments did not contain all of the required content and depth of review.

PNMT needs to ensure that they track measurable progress. Specific data as to how the individual's current progress compares with the previous review should be presented.

The PNMT meeting observed by the Monitoring Team was well organized and the documentation was clearly written.

ISPs were not clearly and comprehensively addressing PNM at-risk conditions. PNM action plans were not implemented timely and completely. Follow-up did not always occur.

For about two-thirds of the observations, positioning and dining plans met criteria, and for about one-third of the observations, transfers were completed correctly.

Individuals who received enteral nutrition did not have thorough reviews and plans regarding continued necessity and use of least restrictive method.

Outcome 1 – Individuals' at-risk conditions are minimized.											
Summary: When individuals needed to be referred to PNMT, they were referred as per Center protocols. This has been the case for all individuals for more than three consecutive reviews, with an exception in Round 16 and one exception this round. Given this sustained high performance, this indicator will be moved to the category of requiring less oversight.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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;	83% 5/6			1/1	1/1	1/1	1/1	1/1		0/1

Comments:
The Monitoring team reviewed six individuals who were referred or should have been referred to the PNMT. Out of the six Individuals, it was good to see that five were noted to be referred to, or reviewed by the PNMT, as appropriate.

Examples of Individuals being referred as appropriate included:

- Individual #118 who was referred for a feeding tube on 5/19/21, bacterial pneumonia on 6/30/21, and emesis on 9/12/21.
- Individual #107 who was referred for weight gain on 4/7/21, aspiration pneumonia on 10/13/21, and bowel obstruction on 10/27/21.

For Individual #42, weight issues were problematic and a referral to PNMT was warranted.

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: Across this set of indicators, performance was about the same as at the last review. In general, PNMT assessments did not contain all of the required content and depth of review. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	Individual is referred to the PNMT within five days of the identification of a qualifying event/threshold identified by the team or PNMT.	63% 5/8			0/1	2/3	0/1	1/1	1/1		0/1
b.	The PNMT review is completed within five days of the referral, but sooner if clinically indicated.	71% 5/7			1/1	2/3		1/1	1/1		0/1

c.	For an individual requiring a comprehensive PNMT assessment, the comprehensive assessment is completed timely.	40% 2/5			1/1	1/2	1/1		0/1		
d.	Based on the identified issue, the type/level of review/assessment meets the needs of the individual.	63% 5/8			1/1	2/3	1/1	1/1	0/1		0/1
e.	As appropriate, a Registered Nurse (RN) Post Hospitalization Review is completed, and the PNMT discusses the results.	25% 1/4			1/1	0/2			0/1		
f.	Individuals receive review/assessment with the collaboration of disciplines needed to address the identified issue.	13% 1/8			0/1	1/3	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.	25% 1/4				0/2		1/1			0/1
h.	Individual receives a Comprehensive PNMT Assessment to the depth and complexity necessary.	0% 0/5 15% 8/52			0/1 5/10	0/2 2/21	0/1 1/10		0/1 0/11		

Comments:

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

- Individual #118 was referred to the PNMT on 5/19/21 with an assessment completed on 6/18/21. She was still hospitalized at the time the assessment was completed. Assessment was related to two recent hospitalizations (4/14/21, 5/14/21) with tube placement on 4/15/21 and 3/10/21-4/9/21 with confirmed bowel obstruction, resulting in g-tube placement and significant weight loss. Before the assessment was completed, she was again hospitalized for a third time on 6/1/21 with bowel obstruction and sepsis (confirmation pending). The PNMT did pick up the individual, but it was unclear as to why a referral was not made after the first hospitalization.
  - Per the PNMT assessment dated 6/18/21, the PNMT reported her first hospitalization being from 3/10/21 to 4/9/21 with the diagnoses of respiratory distress, constipation, intestinal obstruction, and cerebral palsy. The intestinal obstruction was the same as a bowel obstruction (and reported unresolved vomiting >6 in 30 days) and would be qualifying events for referral and assessment. The second hospitalization from 4/14/21 to 5/14/21 with diagnoses of respiratory problem, small bowel obstruction, shortness of breath, and g-tube placement on 4/15/21. The PNMT initiated a referral on 5/19/21 for this hospitalization, but before an assessment was completed, she was hospitalized

the third time on 6/1/21. The PNMT wrote on 6/18/21, "Once again due to issue regarding bowel obstruction and recent diagnosis of sepsis." It remained unclear why she was not reviewed or assessed for bowel obstruction with significant weight loss (7.6 pounds from 67.4 to 59.9 pounds from 3/6/21 to 4/12/21) in April 2021. This amount of unplanned weight loss, and the bowel obstruction are both established criteria for referral.

- Individual #102 was seen by the PNMT multiple times for different issues. These included weight, aspiration, and bowel obstruction. He was initially referred on 4/7/21 and reviewed on 4/14/21. He was placed on informal monitoring due to concerns related to weight loss. Although he qualified for referral on 3/26/21 due to a weight of 125.6 lbs., a referral did not occur until 4/7/21. Per the 2020 IRRF, he lost 15 lbs. the previous year from 161.8 on 5/4/19 to 146.8 on 4/25/20. Although the PNMT reported he was still within his EDWR of 133 to 163 lbs. and his normal BMI was 22.2., his albumin, pre albumin, and total protein were low throughout the year.
    - He was again referred on 10/13/21 with a review completed on 10/20/21. He was already on PNMT caseload due to weight instability. On 10/7/21, he was transferred to the ER with suspected aspiration due to two emesis events earlier that day. He returned to El Paso SSLC with confirmed diagnoses of aspiration pneumonia, UTI, and diarrhea. He received antibiotic treatment for pneumonia and UTI. He was transferred back to the medical center on 10/15/21 due to tachypnea and hypotension, but not admitted. He again transferred out on 10/18/21 due to febrile tachypneic and hypoxia. Per RN report on 10/20/21, diagnoses included pneumonia, loose stools, and sepsis possibly due to intraabdominal source with abdomen consistent with high grade bowel obstruction.
    - A third referral was made on 10/27/21 with assessment completed on 11/17/21 after hospitalization from 10/18/21-10/25/21 with bowel obstruction.
    - The individual was hospitalized for aspiration pneumonia from 10/7/21 to 1/8/22. There was no evidence of a RN Post hospitalization assessment.
- Individual #162 was referred on 10/13/21 with assessment completed on 11/10/21 due to diagnosis of aspiration pneumonia. His most recent hospitalization in February 2021 was due to the need for a GJ replacement. Other concerns noted were related to impaired skin integrity on his left buttock. The PNMT stated that he was initially discussed "last week" due to recent diagnosis of pneumonia, but the PNMT was pending further clarification if it was aspiration related. Per the CXR on 10/5/21, findings of bibasilar infiltrates with subsegmental atelectasis right lower lobe, parapneumonic pleural effusions were noted. Additionally, the PCP on 10/7/21 referenced suspected aspiration, so it was determined that a referral to the PNMT was warranted. The individual met criteria for referral on 10/7/21, but the IDT did not meet and make the referral until 10/19/21 resulting in the referral not being made within five days of identification.
- For Individual #161, the PCP reported "left basal infiltrates on chest x-ray" on 8/24/21 likely being caused by aspiration of the Sonic drink that staff gave her on the afternoon of 8/21/21. She was treated at El Paso SSLC and received a referral on 8/25/21, with her review completed on 9/1/21.
- Individual #115 received a diagnosis of pneumonia (though PCP refers to this as aspiration pneumonia, per note dated 10/20/21) following his hospitalization from 10/11/21 to 10/15/21, with transfer back to ER on 10/19/21 due to possible six small emesis events, aspiration pneumonia, and bowel obstruction. Referral was 10/21/21 and review completed on 10/27/21.
- For Individual #42, weight loss of over 21.6 lbs. in the previous ISP year. EDBW range was 92 to 112 lbs. She had a high weight of 113.8 on 10/4/20) and current weight at time of ISP was 92.2. Average intake of 61.5% and 100% of snacks for the past 30 days per IRRF dated 10/12/21 with 12 meal refusals. Per annual nursing assessment she weighed 99 lbs. on 4/5/21, 100 lbs.

on 5/8/21, 98.8 on 7/24/21. Continued weight loss from 7/31/21 at 97.2 through 9/18/21 when she weighed 91 lbs. She lost 8 lbs. in just over four months or 8%. Although she did not technically qualify for referral, a review was warranted, but there was no evidence that this occurred.

f. As the Monitoring Team has discussed with State Office, without signature pages that include dates, it is not possible to determine which members of the PNMT participated in the PNMT assessments. Currently, PNMT documents included a list of participants within the document. Given that PNMT members are licensed clinicians, the Center needs to have a mechanism to verify the participation of each clinician in the PNMT assessment process. The author or person entering information could potentially populate the list of participants without those clinicians having any role in the process or even knowing that they were listed as participants. Other entries in IRIS provided a signature of sorts because the system identifies the author of each entry as the user that entered the system using a password. Such entries are also time-stamped. In its current state, allowing one user to simply include the names of all team members at the bottom of the report does not suffice. Many times, teleconference discussions listed names, and finally, there was an absence of physician participation.

h. The following summarizes some of the strengths and weaknesses noted with the five assessments that the PNMT completed:

- There were no indicators that were noted as present across all the assessments. This was a decline from the previous review when all (three) of the assessments contained the presence of the same six indicators. The areas where decline was noted included:
  - Discussion of pertinent diagnoses, medical history, and current health status, including relevance of impact on PNM needs.
  - Review of the applicable risk ratings, analysis of pertinent risk ratings, including discussion of appropriateness and/or justification for modification.
  - Discussion of the individual's behaviors related to the provision of PNM supports and services.
  - Discussion of medications that might be pertinent to the problem, and discussion of the relevance to PNM supports and services.
  - Evidence of observation of the individual's supports at his/her program areas.
  - Assessment of the individual's current physical status.
- For Individual #118, her medical history was lacking clear discussion of diagnoses and their impact on PNM needs outside of the current health status. The assessment did not review what supports were in place and whether they had been effective in mitigating risks/issues, nor did it provide clear concise recommendations or thresholds for return to PNMT.
- For Individual #102, his assessments lacked clear discussion of medications and their potential impact on PNM functioning/supports. The PNMT assessment in response to the bowel obstruction contained no physical assessment as it was completed while he admitted to the hospital.
- For Individual #162, assessments lacked clear discussion of medications and their potential impact on PNM functioning/supports. Observations were noted, but lacked evidence of clear physical exam/assessment. Assessment stated that he had supports to minimize risk of aspiration, such as HOBE at 45 degrees. No evidence that this was evaluated considering his recent aspiration pneumonia. Monitoring was provided, but three of 11 instances were related to HOBE. Goals were for exit criteria rather than for IHCP, such as, there will be 100% compliance with HOBE per the PNMP as evidenced by monitoring; The person will have no episodes of aspiration pneumonia for the next three months. None of the goals were

related to behaviors and oral care that were identified as a possibly related issue because he had a history of problem behaviors during oral care. There was no evidence that they made any observations of this activity.

- For Individual #115, it was unclear why a comprehensive evaluation was not completed for the hospitalization occurring on 10/11/21 due to aspiration pneumonia. The last evaluation was 2/8/18 for emesis and he had had three episodes of aspiration pneumonia in 2018, and two in 2017.

Outcome 3 – Individuals' ISPs clearly and comprehensively set forth plans to address their PNM at-risk conditions.											
Summary: Overall, scores were low for this set of indicators, and were even slightly lower than the last review. ISPs were not clearly and comprehensively addressing PNM at-risk conditions. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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).	13% 2/16		0/2	0/2	0/2	1/2	0/2	1/2	0/2	0/2
b.	The individual's plan includes preventative interventions to minimize the condition of risk.	17% 3/18	0/2	1/2	0/2	0/2	0/2	1/2	1/2	0/2	0/2
c.	If the individual requires a PNMP, it is a quality PNMP, or other equivalent plan, which addresses the individual's specific needs.	67% 4/6 97% 69/71			1/1 14/14	1/1 14/14	0/1 13/14	1/1 14/14	1/1 14/14		0/1 0/1
d.	The individual's ISP/IHCP identifies the action steps necessary to meet the identified objectives listed in the measurable goal/objective.	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 the clinical indicators necessary to measure if the goals/objectives are being met.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
f.	Individual's ISPs/IHCP defines individualized triggers, and actions to take when they occur, if applicable.	0% 0/18	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2	0/2
g.	The individual ISP/IHCP identifies the frequency of monitoring/review of progress.	11% 2/18	1/2	1/2	0/2	0/2	0/2	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 #198 – weight and falls; Individual #201 -falls and choking; Individual #118 – aspiration, and Constipation/Bowel Obstruction; Individual #102 – aspiration and weight; Individual #162 – aspiration and falls; Individual #161 – aspiration and falls; Individual #115 – aspiration and falls; Individual #13 – falls and choking; and Individual #42 – falls and weight.

a. Overall, ISPs/IHCPs did not sufficiently address individuals' PNM needs as presented in the PNMT assessment/review or PNMP. The positive exceptions were for Individual #162 – falls, and Individual #115 – falls.

b. Overall, ISPs/IHCPs did not include preventative physical and nutritional management interventions to minimize the individuals' risks. The positive exceptions were for Individual #201 - choking; Individual #161 –falls; and Individual #115 – falls.

c. Six individuals in the review group had PNMPs/Dining Plans. It was positive that four of the six PNMPs contained the needed components.

- For Individual#162, the PNMP did not provide a full look into their ability to communicate as it primarily referenced the Communication Dictionary.
- It was unclear if Individual #42 required a PNMP because there was no evidence of review to determine need. It is correct that the OT/PT assessment was conducted on 9/28/21, but within the assessment were a number of factors that described what contributed to her high risk for falls and fractures (as identified in the assessment and her IRRF). These factors included Down Syndrome, moderate IDD, seizure disorder, gout, Vitamin D deficiency, and worsening vision with recommendations for cataract surgery. She had experienced an increase in falls over the previous year (nine from five), mostly related to decreased safety awareness and environmental hazards. Further, PT noted decrease in static and dynamic balance from baseline, noting increased sway and narrow base of support, and issues bending to retrieve objects. Additionally, the assessment did not clearly establish that she did not need a PNMP at least in the interim until PT completed direct services).

d. None of the IHCPs included the steps necessary to meet the measurable goal/objective related to Habilitation Therapies.

e. None of the IHCPs identified the necessary clinical indicators related to PNM related supports.

f. None of the IHCPs identified triggers and actions to take should they occur.

g. Two of the IHCPs included the frequency of PNMP monitoring/review of progress. Those that met criteria were for Individual #198– weight; and Individual #201 – falls.

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

Summary: As detailed in the comments below, PNM action plans were not implemented timely and completely. Follow-up did not always occur. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals:								
			198	201	118	102	162	161	115	13	42
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.	9% 1/11	0/2		0/2	0/2	0/1		0/1	0/1	1/2
c.	If an individual has been discharged from the PNMT, individual's ISP/ISPA reflects comprehensive discharge/information sharing between the PNMT and IDT.	N/A									

Comments:
a. For 18 risks, criteria were not met regarding whether the individuals' ISPs provided evidence that the action plan steps were completed within established timeframes, and, if not, IPNs/integrated ISP progress reports provided an explanation for any delays and a plan for completing the action steps.

b. One of the 11 risks contained evidence that the IDT met and acted because of a change in status (Individual #42).

- For Individual #198 (weight), in January 2021, he weighed 123.80 with steady weight gain through November 2021 to 156.60. In December 2021, he dropped 16.60 lbs. to 140 on 12/4/21.
- For Individual #198 (falls), the IDT met and reported that COS related to medication be completed by 11/29/21. There was no evidence that this occurred.
- For Individual #118 (aspiration, SBO), there was no evidence that the IDT modified her health care plan to adequately reflect her COS following the three hospitalizations for pneumonia, weight loss, and bowel obstruction. The PNMT did conduct ongoing review and monitoring every two to three weeks of her positioning and weight, and developed a plan for pleasure feedings as of 9/1/21. Over this time, her weight stabilized, and output was stable. MBSS was completed on 8/24/21 with moderate oral pharyngeal dysphagia. IDT agreed to start oral pleasure feedings, although she appeared to not perform well during bedside or in MBSS. Although monitoring completed in July and August 2021 showed 0% (0/9) correct positioning, there was no evidence of comments related to this, other than to follow-up next week.
- For Individual #102 (aspiration), there was insufficient rationale as to why the PNMT did not conduct an assessment rather than only a review. The IHCP was not updated since 5/2/21 and there was no clear etiology established, therefore, preventative actions steps could not be accurately determined. The IHCP did not reflect changes throughout the year particularly as they began oral pleasure feedings. Pleasure feedings were discontinued in March 2021 prior to the last revision, but again resumed in June/July 2021. The PNMP did not indicate that they were put on hold until 12/1/21 and the PNMT evaluationss did not clearly discuss this occurrence. There was also no evidence of an ISPA related to the first hospitalizations until he was discharged after the most recent event. The ISPA that was held occurred on 11/22/21 contained no pre-discharge planning,.
- For Individual #102 (weight), the individual had significant ongoing weight loss throughout the year without IDT referral or PNMT self-referral until April 2021. Per 2020 IRRF, he lost 15 lbs. the previous year from 161.8 on 5/4/19 to 146.8 on 4/25/20, though they reported he was still within his EDWR of 133 to 163 lbs. and his normal BMI was 22.2. Albumin, pre albumin and total protein were low throughout the year. No ISPAs were submitted for that time period.
- For Individual #162 (aspiration), the IDT and PNMT did not take the time to create a consistent plan to ensure that they adequately addressed the identified etiology of his aspiration risk. The PNMT did not conduct a physical examination and did not assess his HOBE, nor did they identify why or when it had been changed from 30 degrees to 45 degrees. The ISPA held on 11/16/21 to discuss the PNMT recommendations stated that OT would update the IHCP on choking and aspiration to reflect HOBE at 45 degrees.

- For Individual #115, there was no evidence of IDT follow-up on 12/8/21 as planned related to monitoring recommended by PNMT. The PNMT did not conduct a comprehensive assessment post aspiration pneumonia and did not explore the impact of high residuals on aspiration risks
- For Individual #13, there was a lack of consistency when reviewing the occurrence of falls.
- For Individual #42 (falls), the IDT did a nice job and met on 11/5/21 to discuss falls. She had one prior fall in the last three months. On 9/12/21, she lost her footing and fell forward breaking her fall with her hands. The door threshold may have contributed to this fall. The second fall on 11/3/21 occurred in the common area of her home. She was sitting on the arm rest and the recliner tipped forward and she he hit her forehead, eye, and left knee on the floor.
- For Individual #42 (weight), an ISPA dated 7/9 21 was to discuss weight due to reports of meal refusals, however, weight was not directly discussed during this meeting. Caloric intake increased on 5/19/21 from 1500 to 1800 and she was to be provided a supplement if she refused or ate less than 50% (7/7/21) . They also increased calories to 2400 ADA diet with continued Glucerna supplement for meal refusals and intake <50% on 8/12/21. RCA hypothesized that those refusals might be related to recent move to A dorm and she asked to return to the cottage home. No discussion of data related to meal refusals or other etiology related to weight loss between August 2020 and April 2021. RCA documentation from follow-up on 9/8/21 recommended that they would continue to monitor her weight, sleep log, and meal refusals.

c. At the time of this review, none of the review group had been discharged from PNMT.

Outcome 5 - Individuals PNMPs are implemented during all activities in which PNM issues might be provoked and are implemented thoroughly and accurately.			
Summary: Performance was about the same as in previous reviews. That is, for about two-thirds of the observations, positioning and dining plans met criteria, and for about one-third of the observations, transfers were completed correctly. This indicator will remain in active monitoring.			
#	Indicator	Overall Score	
a.	Individuals' PNMPs are implemented as written.	64% 25/39	
b.	Staff show (verbally or through demonstration) that they have a working knowledge of the PNMP, as well as the basic rationale/reason for the PNMP.	Not rated	

Comments:
a. The Monitoring Team conducted 39 observations of the implementation of PNMPs/Dining Plans. Based on these observations, individuals were positioned correctly during 13 out of 20 observations (65%). Staff followed individuals' dining plans during 11 out of 16 mealtime observations (69%). Staff completed transfers correctly during one out of three observations (33%).

The following provides more specifics about the observations:

- Regarding Dining Plan implementation, the errors that occurred often related to staff and the individuals not positioned correctly at mealtime.
- Regarding the few problems with positioning, individuals were not positioned correctly. It was positive that necessary adaptive equipment/supports were present, and staff used equipment correctly.
- The Monitoring Team observed three transfers, and for the most part, staff set-up and the actual transfer were done safely, using general transfer skills, and ensured individuals participated with the maximum level of independence, when possible. Process breakdown was noted post transfer when only one of three staff (33%) positioned the individual upon completion.

Individuals that Are Enterally Nourished

Outcome 1 – Individuals receive enteral nutrition in the least restrictive manner appropriate to address their needs.											
Summary: Individuals who received enteral nutrition did not have thorough reviews and plans regarding continued necessity and use of least restrictive method. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	If the individual receives total or supplemental enteral nutrition, the ISP/IRRF documents clinical justification for the continued medical necessity, the least restrictive method of enteral nutrition, and discussion regarding the potential of the individual's return to oral intake.	0% 0/5			0/1	0/1	0/1	0/1	0/1		
b.	If it is clinically appropriate for an individual with enteral nutrition to progress along the continuum to oral intake, the individual's ISP/IHCP/ISPA includes a plan to accomplish the changes safely.	0% 0/5			0/1	0/1	0/1	0/1	0/1		

Comments:
a. and b. Five individuals in the review group received enteral nutrition.

- For Individual #118, the IRRF was not updated since the previous ISP in October 2020. Therefore, the medical necessity of the tube was not addressed and there was no clear plan (with measurable goals) for return to oral pleasure feedings.
- For Individual #102, the medical necessity for continued tube use was not clearly established. Per the IRRF, "Due to refusals to participate in oral intake at mealtime and trials during the assessment, enteral introductions of nutrition, hydration and medication continue to be most appropriate to meet his needs and support weight stability due to a history of weight loss." However, it was stated that enteral intake was not related to oral motor status at the last monitoring in January 2021 indicated continued oral motor skills to manage prescribed textures.
- For Individual #162, the IRRF stated the IDT agreed with the recommendation of high risk because he had numerous supports in place to mitigate the risk of aspiration and long-term use of GJ tube, which decreases oral motor coordination. The IDT further stated that a less restrictive method of nutrition was "not a consideration at this time." He had a history of aspiration pneumonia and risk for silent aspiration. There was a reference to PO trials in the OT/PT assessment, but the dates were not

documented. The clinician stated that his performance revealed his continued need for enteral nutrition and that skilled therapy would not only impact his aspiration risk, but would also result in disregarding his clear refusal communication. This information was not included in his IRRF.

- For Individual #161, the IRRF reported that the IDT discussed the medical necessity for the G-tube and agreed that it as a medically necessary support. Included in the IRRF were behaviors, such as disrupted movements, agitation, and self-injurious behaviors that can make meals or medication administration by mouth unsafe and lead to increased risk of choking and/or aspiration. There were no instructions as to when tube feedings should be administered rather than oral intake. Her PNMP described oral med administration, but listed G-tube as alternative. There were no instructions for when or why it may be decided to give meds via tube. Her OT/PT assessment indicated that she received all nutrition, hydration, and medication by mouth. This was not clearly stated in the IRRF. There was a description of her oral skills included in the OT/PT assessment that were also not addressed in the IRRF.
- For Individual #115, the Aspiration Risk section of the IRRF discussed why he should remain at high risk: multiple medical diagnoses and medical supports. He had chronic respiratory failure, latent tuberculosis, allergic rhinitis, excessive drooling, epilepsy, GJ tube, and history of pneumonia, including aspiration. Nebulizer treatments were prescribed twice daily. There was no discussion as to why or when he initially received a tube or why it was changed to a GJ tube. There was no discussion of the medical necessity and no rationale for why he might not be a candidate for oral intake. The OT/PT assessment (nor the PNMT review) discussed his history related to tube placement, but does document the following: last ISP year he was assessed for possible pleasure feedings.

As indicated in the PNM audit tool, a plan for return to oral intake should include the following components, as appropriate:

- Staff training required prior to implementation.
- Staff roles and responsibilities (e.g., implementation and monitoring)
- Time and schedule of interventions.
- Specific triggers for when the plan should be stopped in the short-term.
- Milestones for proceeding with or indicators for discontinuing the plan in the longer-term.
- Documentation requirements (i.e., method for tracking progress); and
- Frequency of assessments and staff responsible.

Outcome 2 – For individuals for whom it is clinically appropriate, ISP plans to move towards oral intake are implemented timely and completely.											
Summary: There were no plans in place. This will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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.	N/A									
Comments: a. Due to the absence of measurable plans (Outcome 1 Indicator a) this indicator was rated as N/A.											

Section P: Physical and Occupational Therapy

<u>Substantial Compliance – Exited Status</u>

One of the provisions of this section have met and achieved substantial compliance: P1. As a result, indicators 2a-e are no longer monitored.

<u>Sustained High Performance – Less Oversight Status</u>

Two of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, one additional indicator was moved to this category.

<u>Section Summary</u>

Criteria were not met for any of the individuals for any of these indicators regarding progress on OT/PT supports, services, and therapies.

Individual's ISP/ISPA did not include strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.

With improvement in goals, strategies, and implementation, progress can be assessed (indicator 4.a).

Assistive/adaptive equipment was the proper fit for all but one individual for this review. This high performance has been sustained for three consecutive reviews.

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: Criteria were not met for any of the individuals for any of these indicators regarding progress on OT/PT supports, services, and therapies. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	0% 0/5	0/1					0/1	0/1		0/2

#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion.	0% 0/5	0/1					0/1	0/1		0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal.	0% 0/3							0/1		0/2
d.	Individual has made progress on his/her OT/PT goal.	0% 0/3	0/1						0/1		0/1
e.	When there is a lack of progress or criteria have been achieved, the IDT takes necessary action.	0% 0/3	0/1						0/1		0/1

Comments: a. through e. Of the individuals in the review group, three were identified as requiring OT/PT supports and/or services.

- For Individual #198, per ISPA held on 11/22/21 he had four falls in the last 30 days. Missing information included dates and circumstances around these four falls. There was no evidence that the Physical Therapist reviewed any of these incidents. Without an update assessment related to falls in November 2021, it was not clear as to whether he would benefit from OT/PYT services or a PNMP
- For Individual #161, the OT/PT assessment did not provide clear justification as to why she would not benefit from OT/PT services. In the assessment, it stated that she had received skilled PT during the ISP year, but did not state clearly why or what it entailed. The assessment should state the purpose of the therapy, the goals, and compare prior and current (if applicable) course of treatment. The individual had falls and required fluctuating levels of assistance for transfers and ambulation depending on behaviors. Her static and dynamic sitting balance were good/good minus, standing is fair plus. She required support for dynamic movements. The assessment contained the statement "PNMP meets their needs, and no skilled OT or PT is warranted." This statement was offered with no rationale despite identifying some issues within the report.
- Individual #115 was identified as having a tentative independence goal in the OT/PT assessment. OT/PT stated that he already had a SO to complete this walking activity daily, and reported that he sometimes participated and sometimes refused and that the "The goal has been met." QIDP monthly summary stated only that "Walking is on the daily schedule and is being followed." It was, however, not clear if the independence goal was being followed by the PT.
- Individual #42 had two goals. One was focused on foot clearance and the other on retrieving objects from ground. For foot clearance goal, the goals were not included in the assessment or ISP, but rather only in an IPN. The only QIDP monthly summary was for September 2021. No reviews were noted for October and November 2021. For retrieval goal, there were PT IPNs indicating that she participated in skilled therapy related to the two goals listed in the spreadsheet. The IPNs were narrative with little to no data relative to the specific goals and how she was performing. There was no monthly summary to draw conclusions about her specific progress relative to the stated goals.

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: Performance was about the same as at the last review, with some indicators scoring higher and some lower. They will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 198	201	118	102	162	161	115	13	42

a.	The individual's ISP includes a description of how the individual functions from an OT/PT perspective.	63% 5/8	0/1	1/1		1/1	1/1	1/1	1/1	0/1	0/1
b.	For an individual with a PNMP and/or Positioning Schedule, the IDT reviews and updates the PNMP/Positioning Schedule at least annually, or as the individual's needs dictate.	28% 2/7			1/1	0/1	0/1	0/1	1/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	0% 0/2							0/1		0/1
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.	100% 4/4			1/1	1/1	1/1	1/1			

Comments:

a. ISPs did not consistently include concise, thorough descriptions of individuals' OT/PT functional statuses. For three of eight individuals, the ISPs did not provide clear descriptions of the individuals' level of independence or their gross and/or fine motor skills. Therapists should work with QIDPs to make needed improvements and ensure that the OT/OT assessment summaries provide a basis for these that is understandable to the IDT.

b. For five of seven applicable individuals, the ISP did not document a review of the PNMP and/or Positioning Schedule. 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. Therapists should work with QIDPs to make improvements.

c. Individual's ISP/ISPA did not include strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.

- For Individual #42, Direct PT was listed as a recommendation intended for approval by the IDT. There was no indication that this was reviewed or approved by the IDT.

d. It was positive that 100% (4/4) of the individuals needing to have plans revised and approved were seen by and discussed by the IDT.

Outcome 4 – Individuals' ISP plans to address their OT/PT needs are implemented timely and completely.											
Summary: These indicators will remain in active monitoring. With improvement in goals, strategies, and implementation, indicator a can be assessed in the future.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42

a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to OT/PT supports are implemented.	N/A									
b.	When termination of an OT/PT service or support (i.e., direct services, PNMP, or SAPs) is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve the change.	0% 0/2									0/2

Comments:
a. N/A due to none of the goals being measurable.

b. Individual #42 did not have an ISPA in response to being discharged from Physical Therapy. She was discharged from direct PT services on 11/12/21 related to standing posture and static/dynamic balance. An ISPA was held on 12/7/21 to discuss discharge from direct PT, but this was nearly one month after discharge summary. Individual was discharged from direct PT services due to continued noncompliance and recent onset of agitation with therapy attempts. There was no evidence that the PT attempted to seek remedy for this issue with the IDT.

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

Summary: Assistive/adaptive equipment was the proper fit for all but one individual for this review. This high performance has been sustained for three consecutive reviews and as a result, indicator c will be moved to the category of requiring less oversight.

#	Indicator	Overall Score	Individuals:								
			60	58	40	49	127	117	6	82	115
a.	Assistive/adaptive equipment identified in the individual's PNMP is clean.	Due to the Center's sustained performance, these indicators were moved to the category of 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.	95% 18/19	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1
#	Indicator		172	43	107	4	152	5	59	66	200
c	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1	1/1	0/1	1/1	1/1	1/1	1/1	1/1	1/1
#	Indicator		161								
c.	Assistive/adaptive equipment identified in the individual's PNMP appears to be the proper fit for the individual.		1/1								

Comments:
c. Individual's assistive/adaptive equipment was seen to be the proper fit for all but one individual. The wheelchair for Individual #107 did not fit the identified leg discrepancy.

Section Q: Dental Services

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Three of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, two additional indicators were moved to this category.

Section Summary

The Center continued without a Dental Director. While the Center had not been able to hire a facility dentist to date, they had engaged two community dentists to assist with providing annual dental examinations, cleanings, and needed dental treatments, including some ability to use anesthesia.

The center employed two full-time registered dental hygienists (RDHs). They knew the individuals well, including their strengths and their needs.

Although timeliness of annual dental exams remained an issue, the quality of the annual dental examinations often met the requirements. The quality of dental summaries also remained good.

There were still delays for some individuals due to the limited availability of dental services requiring general anesthesia. Even so, proper procedures were followed for the two individuals who received general anesthesia for dental care.

Two monitoring indicators showed sustained high performance:

- Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.
- If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.

The dental hygienists were using desensitization strategies to promote being able to do dental exams, cleanings, and care in the dental chair. However, there were several people with significant behavioral issues that impacted this and there was not a lot of evidence of the involvement of behavior specialists in developing behavior plans to help achieve this goal.

Outcome 3 – Individuals receive timely and quality dental examinations and summaries that accurately identify individuals' needs for dental services and supports.											
Summary: Although timeliness of exams remained an issue, the quality of the annual dental examinations often met the requirements. The quality of dental summaries also remained good. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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.	Due to the Center's sustained performance, this indicator was moved to the category requiring less oversight.									
	ii. On an annual basis, individual has timely dental examination within 365 of previous, but no earlier than 90 days from the ISP meeting.	38% 3/8	0/1		1/1	0/1	1/1	0/1	0/1	0/1	1/1
	iii. Individual receives annual dental summary no later than 10 working days prior to the annual ISP meeting.	Due to the Center's sustained performance, this indicator was moved to the category requiring less oversight.									
b.	Individual receives a comprehensive dental examination.	78% 7/9	1/1	1/1	1/1	0/1	1/1	1/1	0/1	1/1	1/1
c.	Individual receives a comprehensive dental summary.	89% 8/9	1/1	1/1	1/1	1/1	1/1	1/1	1/1	1/1	0/1

Comments:
a. Three of eight individuals, that were not newly admitted, had timely dental examinations within 365 days of the previous exam, but no earlier than 90 days from the ISP meeting.

- For Individual #198, his annual dental exam was completed on 5/5/21. His prior annual exam was dated 2/13/20. His dental exam was not completed prior to his annual ISP meeting.
- For Individual #118, her annual dental exam was completed on 8/13/21 which was within 365 days of her previous exam and within 90 days of her annual ISP meeting.
- For Individual #102, his annual exam was completed on 5/14/21. His prior annual exam was dated 2/27/20. His dental exam was not completed prior to his annual ISP meeting.
- Individual #162, had multiple dental exams documented as an annual exam (5/17/21, 8/9/21) both were within 365 days of his previous annual exam (dated 8/18/20) but were not within 90 days of his annual ISP meeting held on 12/1/20. He did, however, have a document labeled annual dental summary (11/9/21) within 90 days of his annual ISP meeting.
- Individual #161 had visits labeled as annual exams on 5/14/21 and 8/23/21 with an annual summary dated 6/16/21. These did not meet the 365-day requirement, as her prior annual exam was dated 2/14/20. They were also completed after her annual ISP meeting on 3/10/21.
- For Individual #115, His annual dental exam dated 5/14/21 was not within 365 days of his previous exam dated 2/13/20. It was completed after his annual ISP meeting on 3/23/21.

- For Individual #13, His annual dental exam dated 5/14/21 was not within 365 days of his previous exam dated 1/24/20. It was completed after his annual ISP meeting on 2/3/21.
- For Individual #42, her annual dental exam was completed on 7/21/21 which was within 365 days of her previous exam, and it was also within 90 days of her annual ISP meeting.

b. It was positive that seven of the nine annual dental examinations included all required components, except for recall frequency for Individual #102 and Individual #115.

c. Annual dental summaries included all required components with one exception. For Individual #42, the summary noted that general anesthesia was effective, but did not address pretreatment sedation. There was no documentation to support that pretreatment sedation had been considered or attempted and not successful prior to the determination that general anesthesia should be used for dental treatment.

Outcome 5 – Individuals receive necessary dental treatment.											
Summary: It was positive to see that while the Center was not able to hire a facility dentist to date, they had engaged two community dentists to assist with providing annual dental examinations, cleanings, and needed dental treatments. There were still delays for some individuals due to the limited availability of dental services requiring general anesthesia. That being said, the Center showed sustained high performance on indicators b and d. Both will be moved to the category of requiring less oversight. The others will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
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.	71% 5/7	1/1	1/1	0/1		1/1	1/1		0/1	1/1
b.	Twice each year, the individual and/or his/her staff receive tooth-brushing instruction from Dental Department staff.	100% 7/7			1/1	1/1	1/1	1/1	1/1	1/1	1/1
c.	Individual has had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines unless a justification has been provided for not conducting x-rays.	57% 4/7	1/1	1/1	0/1		0/1	1/1		0/1	1/1
d.	If the individual has a medium or high caries risk rating, individual receives at least two topical fluoride applications per year.	83% 5/6	1/1		1/1		1/1	1/1		0/1	1/1
e.	If the individual has need for restorative work, it is completed in a timely manner.	50% 2/4			0/1			1/1		0/1	1/1

f.	If the individual requires an extraction, it is done only when restorative options are exhausted.	N/A									

Comments:

a. Five of seven individuals had prophylactic care at least twice a year, or more frequently based on individual needs. Individual #102 and Individual #115 were not scored for this monitoring indicator because they were edentulous. No periodontal records were submitted for Individual #118. Individual #13's dental records noted poor cooperation and multiple refusals to go to the dental clinic or cooperate when there.

b. Documentation indicated that seven of seven individuals received tooth-brushing instruction from the dental department staff. Individual #198 and Individual #201 were independent in their dental care and it was noted that dental care instruction was not needed.

c. Four of seven individuals had x-rays in accordance with the American Dental Association Radiation Exposure Guidelines.

- Individual #118's documentation indicated that x-rays were last completed in 2018. There was a recommendation to complete x-rays under general anesthesia.
- Individual #162 had not had x-rays since 2016. The dental record documented multiple failed attempts. There was no evidence of a systematic approach to determining the timing of dental care under anesthesia.
- For Individual #13, attempts at x-ray had been unsuccessful due to poor cooperation. There was no evidence of a systematic approach to determining the timing of dental care under anesthesia.

d. It was positive to see that five of six individuals with a medium or high caries risk rating received at least two topical fluoride applications per year. Individual #13 received one application, later attempts had not been successful due to refusals. The annual dental exam did not document attempt to work with the individual to gain acceptance of the treatment.

e. For two of four individuals, restorative work was completed in a timely manner.

- Restorative work was completed timely for Individual #161 and Individual #42.
- For Individual #118, last dental care was completed in 2018 under general anesthesia.
- Individual #13 had not been cooperative for dental care. An exam under general anesthesia was recommended, but had not yet been completed due to limited access to general anesthesia.

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

Summary: None of the individuals in the physical review group had dental emergencies, so this indicator was not rated. These indicators will continue in active monitoring.

Individuals:

#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	If individual experiences a dental emergency, dental services are initiated within 24 hours, or sooner if clinically necessary.	N/A									

b.	If the dental emergency requires dental treatment, the treatment is provided.	N/A									
c.	In the case of a dental emergency, the individual receives pain management consistent with her/his needs.	N/A									
Comments: a-c. Based on the documentation provided, during the six months prior to the review, none of the nine individuals in the physical health review group had dental emergencies.											

Outcome 9 – Individuals who need them have dentures.											
Summary: This indicator did not apply to any of the individuals in the review group. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	If the individual is missing teeth, an assessment to determine the appropriateness of dentures includes clinically justified recommendation(s).	Given the Center's sustained performance, this indicator was moved to the category requiring less oversight, so was not reviewed.									
b.	If dentures are recommended, the individual receives them in a timely manner.	N/A									
Comments:											

Section R: Communication

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Four of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary
All communication goals, except for one, were lacking in their clinical relevance and their measurability. The monthly progress reports did not include specific data or meaningful analysis.

None of the individuals' annual assessments contained the components needed to be considered comprehensive.

ISPs did not thoroughly describe communication and include plans and strategies as recommended in the communication assessment.

Without measurable goals and without implementation, progress cannot be assessed.

About two-thirds of individuals had their communication device present and used in a functional manner.

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: All goals, except for one, were lacking in their clinical relevance and their measurability. The monthly progress reports did not include specific data or meaningful analysis. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	Individual has a specific goal(s)/objective(s) that is clinically relevant and achievable to measure the efficacy of interventions.	8% 1/12	1/2	0/1	0/1		0/3	0/1	0/1	0/1	0/2

b.	Individual has a measurable goal(s)/objective(s), including timeframes for completion	8% 1/12	1/2	0/1	0/1		0/3	0/1	0/1	0/1	0/2
c.	Integrated ISP progress reports include specific data reflective of the measurable goal(s)/objective(s).	0% 0/11	0/2		0/1		0/3	0/1	0/1	0/1	0/2
d.	Individual has made progress on his/her communication goal(s)/objective(s).	0% 0/10	0/2	0/1	0/1		0/1	0/1	0/1	0/1	0/2
e.	When there is a lack of progress or criteria for achievement have been met, the IDT takes necessary action.	0% 0/10	0/2	0/1	0/1		0/1	0/1	0/1	0/1	0/2

Comments:
a. and b. All Individuals (except for Individual #102) had identified needs requiring formal communication supports. It was unclear if Individual #102 required formal supports due to the lack of a clear AAC assessment and supporting documentation. Three individuals (Individual #13, Individual #115, Individual #201) were identified as needing supports, but were not provided with any goal/plan.

All goals, except for one, were lacking in their clinical relevance and their measurability. The goal/objective that was clinically relevant and measurable was for Individual #198 (i.e., Will use AAC to greet familiar/unfamiliar people).

c. through e. For all individuals, the monthly progress reports did not include specific data or meaningful analysis.

- For Individual #102, the narrative in the QIDP monthly summary was identified for October 2021 and described the course of an undated therapy session, but this narrative did not match any of the IPNs submitted by the SLP. There were no measurable data reported and there was no clear data statement as to status of his performance on the goals in the treatment plan. There was also no reporting on the frequency of his attendance or how they planned to manage his no shows and skipped therapy sessions.
- For Individual #162, the QIDP monthly summary reflected the use of a Little Mac instead of the Talkable II, which was what was outlined in her plan.
- For Individual #42's goal, "Will identify common objects (core vocabulary) when they are named in 8/10 trials," IPN dated 10/25/21 for date of session on 10/22 /21 recorded that she required moderate verbal and gestural assistance to complete goal at 80%. There was no method to measure this based on the way the goal was written. Additionally, the narrative of the IPN did not identify which core vocabulary she named during this session.

Outcome 2 – Individuals receive timely and quality communication screening and/or assessments that accurately identify their needs for communication supports.											
Summary: None of the individuals' annual assessments contained the components needed to be considered comprehensive. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42

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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
	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.										
	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.										
b.	Individual receives assessment in accordance with their individualized needs related to communication.										

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

d.	Individual receives quality Comprehensive Assessment.	0% 0/8 31% 20/64	0/1 1/9	0/1 3/5		0/1 4/9	0/1 4/8	0/1 3/9	0/1 2/8	0/1 2/8	0/1 1/8
e.	Individual receives quality Communication Assessment of Current Status/Evaluation Update.	N/A									

Comments:
c. None of the individuals in the review group required or received a screening.

d. None of the individuals' annual assessments contained the components needed to be considered comprehensive.

Components commonly missing included, but were not limited to:
- The individual's preferences and strengths are used in the development of communication supports and services.
- 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.
- A comparative analysis of current communication function with previous assessments.
- Assessment of communication needs [including AAC, Environmental Control (EC) or language-based] in a functional setting, including clear clinical justification as to whether the individual would benefit from communication supports and services.
- Evidence of collaboration between Speech Therapy and Behavioral Health Services as indicated.

It was positive that most, but not all met criteria, as applicable, regarding:
- Discussion of medications that might be pertinent to the problem and a discussion of relevance to communication supports and services.

The Center should focus most on the following sub-indicators:
- 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 effectiveness of current supports, including monitoring findings.
- As appropriate, recommendations regarding the way 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: Performance was about the same as at the last review. That is, ISPs did not thoroughly describe communication and include plans and strategies as recommended in the communication assessment. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	198	201	118	102	162	161	115	13	42
a.	The individual's ISP includes a description of how the individual communicates and how staff should communicate with the individual, including the AAC/EC system if he/she has one, and clear	50% 4/8	0/1	1/1		0/1	1/1	0/1	1/1	1/1	0/1

	descriptions of how both personal and general devices/supports are used in relevant contexts and settings, and at relevant times.										
b.	The IDT has reviewed the Communication Dictionary, as appropriate, and it comprehensively addresses the individual's non-verbal communication.	0% 0/7	0/1			0/1	0/1	0/1	0/1	0/1	0/1
c.	Individual's ISP/ISPA includes strategies, interventions (e.g., therapy interventions), and programs (e.g., skill acquisition programs) recommended in the assessment.	38% 3/8	0/2		1/1		2/2	0/1			0/2
d.	When a new communication service or support is initiated outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve implementation.	N/A									

Comments:

a. For 50% of the individuals, it was positive that the IDT included a general description of how the individual communicated and how staff can assist in bridging gaps in communication.

b. Seven of the nine individuals that required communication dictionaries, did not have those dictionaries appropriately reviewed by the IDT.

c. For two of the individuals, it was positive that, as applicable, IDTs included in the individuals' ISPs/ISPAs the communication strategies, interventions, and programs recommended in assessments or initiated outside of an annual ISPA.

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

Summary: Without measurable goals and without implementation, progress cannot be assessed. These indicators will remain in active monitoring.

#	Indicator	Overall Score	Individuals: 198	201	118	102	162	161	115	13	42
a.	There is evidence that the measurable strategies and action plans included in the ISPs/ISPAs related to communication are implemented.	0% 0/7	0/2		0/1		0/3				0/1
b.	When termination of a communication service or support is recommended outside of an annual ISP meeting, then an ISPA meeting is held to discuss and approve termination.	0% 0/2									0/2

Comments:

a. The Monitoring Team reviewed the ISP integrated monthly reviews to determine whether the measurable strategies related to communication were implemented. As described above regarding Outcome 1, one individual (i.e., Individual #102) had a measurable goal. Based on the QIDP monthly integrated progress reports and SAP data submitted for review, it stated that direct speech therapy was not warranted, and this was restated in the ISP, yet the eval indicated that he was participating at the time of the assessment in

direct service. The remaining applicable individuals (i.e., who needed formal communication supports) did not have measurable goals/objectives integrated in their ISPs/ISPAs

b. For Individual #42, the Monitoring Team was unable to determine if or when direct therapy had been discontinued due to incomplete documentation.

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: About two-thirds of individuals had their communication device present and used in a functional manner. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	86	42	16	28	40	128	127	67	169
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.	71% 10/14	1/1	1/1	1/1	1/1	1/1	1/1	0/1	0/1	
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.	64% 7/11			1/1	1/1	1/1	1/1	0/1	0/1	
#	Indicator		54	6	82	115	30				
a.	The individual's AAC/EC device(s) is present in each observed setting and readily available to the individual.		1/1	0/1	1/1	0/1	1/1				
b.	Individual is noted to be using the device or language-based support in a functional manner in each observed setting.		0/1	0/1		1/1	1/1				
c.	Staff working with the individual are able to describe and demonstrate the use of the device in relevant contexts and settings, and at relevant times.	Not Rated									

Comments:
a. and b. Based on observations, two of 13 individuals did not have their AAC devices with them, and five of 12 individuals were not using their language-based supports in a functional manner.

- For Individual #67, she had a joystick that was designed to turn on the radio in her room, however, there was no clear reason provided as to why this should not be available in other locations.
- Individual #54 did not have his Talking Photo Album within reach as stated in his plan.
- For Individual #127, her joystick was in an awkward location and was not easily reachable, thus, requiring her to have assistance to access and utilize it.

Section S: Habilitation, Training, Education, and Skill Acquisition Programs

Substantial Compliance – Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Eight of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary
There were few (or no) SAPs for two-thirds of the individuals. This might be somewhat related to effects of COVID restrictions

For those SAPs that were in place, about one-third were not written in measurable terms.

Although there were not many SAPs and there were some problems with the choice of SAPs, the Center was attentive to making sure that data were collected and that reliability was checked.

About one-quarter of SAPs were showing progress. If the individual was not making progress, actions were not taken.

More SAPs (and a higher percentage) met criteria for content than ever before.

About half of the SAPs were observed to be implemented correctly. All SAPs had a schedule for the Center to check on integrity.

COVID precautions continued to compete with engagement activities. More than half of the individuals were not regularly engaged when observed. The Center was re-starting attention to and measuring of engagement.

IDTs were reviewing PTS, whether intervention was called for, and then implementing it when that was the case.

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: There were few (or no) SAPs for two-thirds of the individuals. This might be somewhat related to effects of COVID restrictions and the Monitor will leave indicator 1 in the category of requiring les oversight. For those SAPs that were in	Individuals:

place, about one-third were not written in measurable terms. This is indicator 2, which will also remain in the category of requiring less oversight, but for which comments are provided below and for which improved performance is needed for the next review. On the positive, indicator 5 scored at 100%, by far the best performance ever seen. In other words, although there were not many SAPs and there were some problems with the SAPs that were chosen (indicators 2-4), the Center was attentive to making sure that data were collected and that reliability was checked. Also note that for two individuals, all three of the indicators scored 100%. These indicators will remain in active monitoring.											
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
1	The individual has skill acquisition plans.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
2	The SAPs are measurable.										
3	The individual's SAPs were based on assessment results.	88% 15/17	No SAPs	2/2	3/3	3/3	1/2	2/2	1/1	0/1	3/3
4	SAPs are practical, functional, and meaningful.	35% 6/17	No SAPs	0/2	1/3	3/3	0/2	2/2	0/1	0/1	0/3
5	Reliable and valid data are available that report/summarize the individual's status and progress.	100% 17/17	No SAPs	2/2	3/3	3/3	2/2	2/2	1/1	1/1	3/3

Comments:
The Monitoring Team chooses three current skill acquisition plans (SAPs) for each individual for review. There were no SAPs for Individual #23, one SAP for Individual #201 and Individual #173, and two SAPs available for Individual #7, Individual #35, and Individual #30, for a total of 17 SAPs for this review. All individuals should have SAPs.

2. Six SAPs were not measurable because either the objective did not identify a prompt goal level (e.g., Individual #201's bake a pumpkin pie SAP), or no objective timeframe for the goal to be completed was identified (e.g., Individual #119's apply body spray SAP).

3. Individual #201's bake a pumpkin pie SAP, and Individual #30's use a talkable device SAP had no evidence that they were based on assessments results because their FSAs indicated that the individuals possessed the skill.

4. Some SAPs were judged not to be practical or functional because the FSA indicated that the individual possessed the skill. (e.g., Individual #201's bake a pumpkin pie SAP). Other SAPS were judged to be impractical or not functional because they were not clearly related to the individual's vision statement (e.g., Individual #119's use hand sanitizer SAP).

5. All SAPs had interobserver agreement (IOA) demonstrating that the data were reliable. This represents a substantial improvement from the last review when 67% of the SAPs had IOA demonstrating that the data were reliable.

Outcome 2 - All individuals are making progress and/or meeting their goals and objectives; actions are taken based upon the status and performance.											
Summary: Performance was low on these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
6	The individual is progressing on his/her SAPs.	25% 4/16	No SAPs	0/2	0/3	1/3	0/2	0/2		1/1	2/3
7	If the goal/objective was met, a new or updated goal/objective was introduced.	N/A	No SAPs								
8	If the individual was not making progress, actions were taken.	0% 0/12	No SAPs	0/2	0/3	0/2	0/2	0/2			0/1
9	(No longer scored)										

Comments:
6. The majority of SAPs were judged not to be progressing. Individual #119's use hand sanitizer and activate her radio, Individual #201's bake a pumpkin pie, and Individual #91's apply hair products SAPs were progressing. Individual #173's sign pizza SAP did not have data and, therefore, was not scored for this indicator .

7. Individual #119 was improving on her use hand sanitizer and activate her radio SAPs, however, because she had unclear objectives, it was impossible to determine if she achieved her objective.

8. Twelve SAPs were not progressing, however, no actions were documented (e.g., Individual #91's sign toilet), to address the lack of progress. The Behavior Health department should ensure that decisions to continue, discontinue, or modify SAPs are data based.

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: More than half of the assessments did not meet criteria for these indicators. They will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
10	The individual has a current FSA, PSI, and vocational assessment.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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	1/1	0/1	0/1	1/1	1/1	1/1	0/1	0/1	0/1
12	These assessments included recommendations for skill acquisition.	33% 3/9	1/1	0/1	0/1	0/1	0/1	1/1	0/1	0/1	1/1

Comments:

11. Individual #190's vocational assessment, Individual #119 and Individual #173's PSI, and Individual #201 and Individual #7's FSA were not available to the IDT at least 10 days prior to the ISP.

12. Individual #7, Individual #190, Individual #91,, Individual #30, Individual #173, and Individual #201's vocational assessments did not include recommendations for SAPs, or a rationale for why a SAP recommendation was not made.

Outcome 4- All individuals have SAPs that contain the required components.												
Summary: More SAPs (and a higher percentage) met criteria for content than ever before. Comments are provided below. This indicator will remain in active monitoring.			Individuals:									
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
13	The individual's SAPs are complete.	41% 7/17	No SAPs	2/2 18/18	1/3 28/30	1/3 26/29	0/2 14/18	2/2 20/20	1/1 10/10	0/1 8/10	0/3 20/28

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 as 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.

Seven SAPs (e.g., Individual #35's sign phone SAP) were found to contain all 10 components. This represents a dramatic improvement from the last review when none of the SAPs were judged to be complete. Additionally, most SAPs contained the majority of these components. For example, 100% of the SAPs had a plan that included:

- A task analysis
- operational definitions of target behaviors
- relevant discriminative stimuli
- teaching schedule
- specific consequences for incorrect responses
- documentation methodology

Regarding common missing components:

- Additional staff instructions were required for several SAPs. For example, Individual #91's apply hair product SAP clearly presented an operational definition of each step and excellent examples of how to use each prompt level. It did not, however, indicate how the staff should present the untrained steps. That is, do they guide her through the untrained steps, use most-to-less prompting, etc. Individual #35's Facetime with his family SAP was an example of a multiple step SAP that did provide instructions on how staff should approach the training step, and the untrained steps.
- For some SAPs (e.g., Individual #190's complete his trust fund form SAP), it was unclear if training was on just one step, or if all steps were to be reviewed during each training session.

- The behavioral objectives of several SAPs were not measurable because either the desired prompt level was missing (e.g., Individual #201's prepare a pie SAP), and/or the number of months that the SAP needed to be maintained was not identified (e.g., Individual #119's activate her radio SAP).
- A few SAP plans (e.g., Individual #119's activate her radio SAP) were missing maintenance plans.
- An area of improvement from the last review was the use of potent reinforcers following correct responses. El Paso SSLC recently developed a catalog of commonly preferred items, such as leisure activities, watches, etc. that individuals could purchase with SAP tokens. The tokens were given after an individual completed a SAP. Nevertheless, a few SAPs' reinforcement consisted of only staff praise that likely was not a potent reinforcer (e.g., Individual #30's operate her talkable device SAP).
- Specific sub-indicators scored 0 were:
  - Individual #190, for prepare a meal and also for complete form: specific instructions.
  - Individual #91, for apply lotion and for sign toilet: behavior objective; and for apply hair product: specific instructions.
  - Individual #30, for TV: behavioral objective and maintenance/generalization; and for talkable: behavioral objective and consequences for correct responding.
  - Individual #201, for bake a pie: behavioral objective and specific instructions.
  - Individual #119, for hand sanitizer: behavioral objective, consequences for correct responding, and maintenance/generalization; for body spray: behavioral objective and specific instructions; and for radio, behavioral objective, specific instructions, and maintenance/generalization.

Outcome 5- SAPs are implemented with integrity.

Summary: About half of the SAPs were observed to be implemented correctly. All SAPs had a schedule for the Center to check on integrity. These indicators will remain in active monitoring.

Individuals:

#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
14	SAPs are implemented as written.	57% 4/7	No SAPs	1/1	0/1	Refused	1/1	0/1	1/1	1/1	0/1
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.	100% 17/17	No SAPs	2/2	3/3	3/3	2/2	2/2	1/1	1/1	3/3

Comments:
14. The Monitoring Team observed the implementation of seven SAPs. Individual #23 did not have any SAPs and Individual #91 refused to participate in the implementation of her SAP.

Individual #173's sign pizza, Individual #30' s operate her talkable device, Individual #201's bake a pie, and Individual #7's math SAPs were all implemented and scored as written.

The SAP training sheet for Individual #35's sign phone SAP stated that staff should show Individual #35 his phone as the discriminative stimulus for signing phone. The DSP implementing his SAP, however, began the instruction by say sign phone; a verbal prompt

according to his SAP training sheet. Therefore, it was impossible for Individual #7 to complete the SAP independently. Individual #119's apply body spray SAP and Individual #190's complete his trust fund SAP were implemented as the SAP was written. The prompt levels scored by the DSPs for both SAPs, however, were not consistent with the prompt levels that were observed in the training.

Outcome 6 - SAP data are reviewed monthly, and data are graphed.											
Summary: SAPs were reviewed monthly and with sustained high performance, this indicator might be move to the category of requiring less oversight after the next review. It will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
16	There is evidence that SAPs are reviewed monthly.	94% 16/17	No SAPs	2/2	3/3	3/3	2/2	2/2	0/1	1/1	3/3
17	SAP outcomes are graphed.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
Comments: 16. Individual #173's sign pizza SAP was not reviewed in the QIDP monthly reports.											

Outcome 7 - Individuals will be meaningfully engaged in day and residential treatment sites.											
Summary: COVID precautions continued to compete with engagement activities. More than half of the individuals were not regularly engaged when observed. The Center was re-starting attention to and measuring of engagement. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
18	The individual is meaningfully engaged in residential and treatment sites.	44% 4/9	0/1	1/1	1/1	0/1	0/1	0/1	1/1	1/1	0/1
19	The facility regularly measures engagement in all of the individual's treatment sites.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
20	The day and treatment sites of the individual have goal engagement level scores.										
21	The facility's goal levels of engagement in the individual's day and treatment sites are achieved.	N/A due to COVID									
Comments:											

18. The Monitoring Team directly observed all nine individuals multiple times in various settings on campus during the remote virtual review week. The Monitoring Team found Individual #7, Individual #190, Individual #173, and Individual #201 to be consistently engaged (i.e., engaged in at least 70% of the Monitoring Team's observations).

19-21. El Paso SSLC's engagement assessments continued to be suspended due to COVID-19. It was encouraging to learn that regular engagement assessments across the residences and treatment sites was scheduled to begin again around the week of 1/10/22.

Outcome 8 - Goal frequencies of recreational activities and SAP training in the community are established and achieved.											
Summary: Community outings were occurring, but there weren't any individual goals for frequency, training, or activities. Perhaps as COVID precautions are modified, this can occur again at some point. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
22	For the individual, goal frequencies of community recreational activities are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
23	For the individual, goal frequencies of SAP training in the community are established and achieved.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1
24	If the individual's community recreational and/or SAP training goals are not met, staff determined the barriers to achieving the goals and developed plans to correct.	0% 0/9	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1	0/1

Comments:
22. All of the individuals participated in community outings, however, there were no established goals for any individuals for this activity. El Paso SSLC should establish a goal frequency of community outings for each individual, and demonstrate that the goal was achieved.

23. El Paso SSLC did not provide data regarding 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 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.									

PTS: 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: Performance was higher than ever before on these indicators. IDTs were reviewing PTS, whether intervention was called for, and then implementing it when that was the case. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	23	7	190	91	30	35	173	201	119
1	IDT identifies the need for PTS and supports needed for the procedure, treatment, or assessment to be performed and discusses the five topics.	100% 3/3						1/1		1/1	1/1
2	If PTS was used over the past 12 months, the IDT has either (a) developed an action plan to reduce the usage of PTS, or (b) determined that any actions to reduce the use of PTS would be counter-therapeutic for the individual.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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.	100% 1/1						1/1			
4	Action plans were implemented.	100% 1/1						1/1			
5	If implemented, progress was monitored.	100% 1/1						1/1			
6	If implemented, the individual made progress or, if not, changes were made if no progress occurred.	100% 1/1						1/1			

Comments:

The scoring of these indicators was based on a review of Individual #91's 7/19/21 dental exam, Individual #30's 10/8/21 dental exam, Individual #35's 8/30/21 dental exam, Individual #201's 11/5/21 cardiology exam, and Individual #119's 11/9/21 dental exam. Individual #30's PTS was conducted in a community hospital and, therefore, will not be reviewed here. Individual #91's 7/19/21 dental appointment under general anesthesia was cancelled due to medical concerns.

1. Available documentation for Individual #35, Individual #201, and Individual #119's PTS reflected a discussion of each individuals' need for PTS and treatments or strategies were provided to minimize or eliminate the need for PTS.

3-6. Individual #35's monthly visits to the dental desensitization clinic were in his ISP and written as an SO. Documentation indicated that he was attending the dental clinic monthly.

Section T: Serving Residents in the Most Integrated Settings Appropriate to Their Needs

Exited Status

None of the provisions of this section have met and achieved substantial compliance.

Sustained High Performance – Less Oversight Status

Seven of the monitoring indicators of this section were in the category of requiring less oversight at the start of this review. After this review, no additional indicators were moved to this category.

Section Summary

Since the last review, El Paso SSSLC had made several staffing changes among transition staff. The Admissions and Placement Coordinator (APC) started her new position in September, the PMM position had been filled by the previous Transition Specialist, and there was a new Transition Coordinator. They all appeared to be very knowledgeable about the transition needs of the individuals.

The Center had one transition since July 2019, which occurred in December 2021. Center staff scheduled a PMM visit for the individual during the remote review. However, due to the late scheduling and some unavoidable delays that occurred during the visit itself (e.g., traffic), only a partial observation was able to be completed.

The Center had five active referrals. One of the individuals referred was selected by the Monitoring Team for review during this remote visit. Of note, based on the ISPAs reviewed, there had been some significant delays in the implementation of strategies the IDT conceived to address barriers to transition (e.g., inability to attend provider tours due to behavioral challenges during transportation and becoming oriented to a daily schedule that would resemble that of a community setting). Transition staff indicated the IDT attributed this to staffing challenges and obtaining needed materials.

The CLDP contained various pre- and post-move supports. The list of supports, however, was not sufficiently comprehensive.

More detail around ensuring community provider staff are competent in providing support to the individual was needed. Make sure competency tests address the specified criteria for each one of the prioritized needs. The Center might include more information than that in the training it provides, but testing needs to ensure all prioritized support needs are addressed.

Transition staff continued to implement some positive initiatives to promote opportunities for community living for individuals living at the Center. Examples included:

- Monthly in-home living options presentations, discussions, and virtual tours, targeting both individuals and the Center staff that work with them.
- Rolling out the State-Office led initiative for using virtual reality tools to expand community exploration. Transition staff report very positive reactions from both individuals and Center staff.
- Showcasing community providers and settings in the Center's newsletter.
- The APC reported that transition staff were set to begin training with the individual disciplines to assist them in crafting needed and community-specific supports. This training should include a focus on the primary tasks recommended above.

Outcome 1 – Individuals have supports for living successfully in the community that are measurable, based upon assessments, address individualized needs and preferences, and are designed to improve independence and quality of life.											
Summary: The CLDP contained various pre- and post-move supports. The list of supports, however, was not sufficiently comprehensive. More detail around ensuring community provider staff are competent in providing support to the individual was needed. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	74								
1	The individual's CLDP contains supports that are measurable.	0% 0/1	0/1								
2	The supports are based upon the individual's ISP, assessments, preferences, and needs.	0% 0/1	0/1								

Comments: The Center completed one transition since the previous review. Individual #74 transitioned to an HCS group home. The Monitoring Team reviewed this transition and discussed it in detail with the El Paso SSLC Admissions and Placement staff. Of note, El Paso SSSLC had made several recent staffing changes among transition staff. The Admissions and Placement Coordinator (APC) started her new position in September 2021, the PMM position had been filled by the previous Transition Specialist, and there was a new Transition Coordinator. They all appeared to be very knowledgeable about the transition needs of the individuals.

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. This process needs to start with the development of clear and detailed pre-move training supports that include specific competency criteria. Those criteria should answer the question "what are the important things provider staff need to know, and know how to do, to meet an individual's needs?" Once these important things are identified, the IDTs will need to ensure provider staff know, and can perform, each one. Examples of supports that both met and did not meet criterion are described below:

- Pre-move supports: The IDT developed 28 pre-move supports in the CLDP for Individual #74. Some pre-move supports called for items to be delivered at the time of the pre-move site review (PMSR) and some called for the completion of assessments by

the provider nurse within specific timeframes. These were generally measurable. Otherwise, many (21) of the remaining pre-move training supports addressed pre-move training for provider staff. To meet criterion, pre-move training supports should address the content of provider staff training as well as describe the staff to be trained, the training methodologies to be used and the competency criteria. The Center must also describe how it will verify provider staff have the knowledge and competence to provide each individual's unique set of needed supports prior to relinquishing day-to-day responsibility for his or her health and safety. Previously, the Monitoring Team found that Center staff needed to prioritize ensuring that all pre-move training supports provide specific competency criteria for each topic. For this review, while some pre-move training supports provided clear criteria, most did not. The following provides examples of supports that were measurable and those that were not:

- Pre- move training supports for provider staff knowledge and competency indicated the topics to be covered included his social history and reason of admission; proper oral care technique; nursing/health care needs; current diet, weight status, and when to report significant weight changes; and his Physical/Nutritional Management Plan (PNMP), Dining Plan, and Communication Dictionary /Instructions. The pre-move training supports for social history and reason of admission; oral care; diet and weight, and the PNMP, Dining Plan, and Communication Dictionary /Instructions did not provide specific competency criteria.
- In the CLDP, the nursing/health care pre-move training needs were addressed through a series of supports directed either to the provider nurse or to both provider nursing and direct support staff. Some of these had clear criteria, but many did not. For example, measurable criteria in this area included training for 1) provider staff to administer Individual #74's medications as prescribed, and in crushed form and mixed with applesauce or pudding, and 2) provider staff to document on the bowel movement chart every time the individual had a bowel movement and to notify the provider nurse when he had not had a bowel movement in two days. Many others were not measurable, providing only broad topics, without specifying the individualized criteria for staff knowledge. Examples of these supports included training on 1) medium and high-risk areas, 2) side effects to watch for, and what to monitor and report to the provider nurse, and 3) medical conditions/falls and when to call provider nurse and/or 911 for emergencies. Of note, in the PMM Checklist, this group of supports was condensed into one nursing pre-move training support with 13 separate criteria. It appeared that the training requirements related to his medium and high risk areas were not included in this support and were not otherwise represented.
- The pre-move supports did not include training for his Psychiatric Support Plan (PSP) and/or his behavioral history, despite significant staff knowledge needs.
- The Monitoring Team reviewed the Center's pre-move provider testing to assess whether it clearly and comprehensively evidenced staff knowledge and competence, based on the individual's assessments. Overall, the testing still did not fully address many of the assessed needs or what provider staff would likely need to know, or know how to do.
  - The CLDP did not specify any behavioral/psychiatric pre-move training supports. Center staff did provide training in this area, although they did not provide the training materials used for review. Instead, the Monitoring Team compared the sufficiency of the competency testing against the needs described in the pertinent assessments and supports. The competency quiz consisted of four fill-in-the-blank questions. It was positive that the quiz required provider staff to demonstrate knowledge in this manner, rather than relying simply on true-false and/or multiple choice items. However, the quiz did not probe knowledge

comprehensively. For example, the test asked provider staff to name the psychiatric indicators (i.e., physical aggression and self-injurious behavior), but did not require them to describe what his specific behaviors looked like. It required provider staff to name only one of the two antecedents (i.e., over-prompting within a short period of time or not responding to his verbal or gestural communication that he wished to escape tasks or demands). It did not address sexually-inappropriate behavior with staff.

- The PNMP competency test consisted of seven questions and was not sufficiently comprehensive to address important needs. For example, his PNMP supports for choking and aspiration included instructions for medication administration and oral care, a dining plan with individualized feeding instructions, dining equipment (i.e., dycem, plate guard, large maroon spoon, pitcher, and communication placemat), safe swallowing positioning, and moistened ground textures with regular/thin liquids. It also noted he required an upright position during and for 30 minutes after meals, snacks, medication passes, and oral care hygiene activities. The quiz required provider staff to list his diet texture and liquid consistency as well as his assistive dining equipment, but did not probe knowledge of the need to maintain an upright position or his dining plan instructions. With regard to the latter, the documentation also described his impulsivity and decreased safety awareness, as evidenced by his decreased mastication, history of rapid intake, and not responding to redirection. None of these potential factors for increased risk, or how to address them, were included in staff testing.
- The nursing pre-move training support consisted of seven questions. This did not address many of his needs or only in a very broad manner that would not test provider staff knowledge of the important things they needed to do as a result of those needs. The quiz asked provider staff to name the areas of high risk in his Integrated Health Care Plan (IHCP), but did not test staff knowledge of any interventions or monitoring requirements they might need to implement. For example, it did not require any demonstration of knowledge with regard to his high risk for medication side effects, including signs and symptoms or when to notify the nurse. In the same vein, the test posed a question asking for some of his medical diagnoses, but again did not ask provider staff to demonstrate awareness of associated signs and symptoms to monitor and/or when to notify the nurse.
- Based on the CLDP, the IDT often constructed the competency training in stages. For most of the pre-move training supports, an appropriate Center discipline first trained the provider's program manager, who then trained group home and day program staff. However, for review, Center staff only provided the evidence of competency demonstration for the provider program manager, and did not provide evidence of competence for any direct support staff. As a result, it was not possible to measure whether the staff primarily responsible for supporting the individual had the required knowledge or competence to meet his needs.

- Post-Move: The respective IDTs developed 33 post-move supports for Individual #74. Many post-move supports were measurable, but there continued to be examples of post-move supports that used vague language and did not provide clear expectations about needed staff actions or about outcomes. The following provides examples:
  - A post move support indicated he would use a shower chair for bathing in the morning, but it did not state the level of staff assistance needed. Another support indicated he would be providing with "minimum to total" assistance with ADLs (bathing, toileting and dressing), but this did not clarify which level of assistance he required for each task.

- A post-move support for his PSP lacked clarity with regard to the specific provider actions required.

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. This CLDP did not fully and comprehensively address support needs and did not meet criterion. It often did not include post-move supports across many areas of identified need.

- Past history, and recent and current behavioral and psychiatric problems: This sub-indicator did not meet criterion. Individual #74's CLDP included a support that indicated he had a Psychiatric Support Plan (PSP) due to the continued use of psychiatric medications. The support recommended that the important antecedent strategies and environmental modifications continued to be provided as supports, because they had proven successful in keeping his self-injurious behavior and physical aggression at low to no occurrences. No CLDP supports required staff knowledge of the specific nature of his behaviors, or required staff to demonstrate knowledge of the specific antecedent strategies and environmental modifications. Based on assessments provided for review, as recently as 2020, he had a Positive Behavior Support Plan (PBSP) with target behaviors of physical aggression (i.e., hitting, kicking, or slapping staff or peers and self-injurious behaviors, hitting himself on his face, hitting his head against the wall, tearing his clothes or biting his hand). In addition, his ISP and some assessments noted that could be sexually inappropriate with staff, throw items when he is agitated or when he does not want to engage in an activity or task, and becomes impatient when he does not know when his sister is going to pick him up. No CLDP supports addressed these needs for staff knowledge. Of note, the CLDP also did not include a pre-move training support with regard to his behavioral and psychiatric needs. This was a significant oversight.

- Safety, medical, healthcare, therapeutic, risk, and supervision needs: The IDT developed supports in some areas related to safety, medical, healthcare, therapeutic, and risk needs, such as for scheduling of health care appointments. To meet criterion, the IDTs still needed to develop comprehensive supports. Individual #74's Integrated Risk Rating Form (IRRF), PNMP, and assessment included many requirements in these areas, but the CLDP included very few related supports. The following provides examples:
  - The pre-move training support indicated provider staff should be trained to notify nursing if the individual did not have a bowel movement in two days. It also indicated provider staff should be trained on medication side-effects and what to monitor and report to nursing. However, the CLDP did not include any related post-move supports for implementation of these requirements.
  - The IRRF indicated he had high risk in the area of cardiac disease, including a past medical history of a transient ischemic attack and deep vein thrombosis of right his leg. His nursing assessment and pre-move training indicated he required vital signs at least monthly, but the CLDP did not include any post-move supports in that area.
  - His assessments indicated he should have medication side effects monitoring quarterly, but the CLDP did not include a post-move support.
  - The individual had needs for implementation of PNMP supports to prevent choking and aspiration. However, the CLDP did not include post-move supports for many of those, including his dining plan with individualized feeding instructions, dining equipment (e.g., dycem, plate guard, large maroon spoon, pitcher, and communication placemat), or his safe swallowing positioning.
  - The IRRF stated he had a high risk for falls and described supports and falls precautions in the PNMP. In addition to the use of the gait belt, these included a history of sudden impulsive behaviors, sudden lightheadedness and feet shuffling

and fast movements when getting up from sitting, standing or during walking that indicate that he may try and "throw" himself to the ground, positioning instructions that include reflux position, and handling instructions that include verbal cues to slow down if he begins to increase his walking speed. None of these were included in pre-or post-move supports

- What was important to the individual: The CLDP did not identify outcomes important to the individual, but only stated that he was ready to transition. This did not meet criterion. The Monitoring Team reviewed various other documents to identify what was important to the individual, including the ISP, and the Preferences and Strengths Inventory (PSI). For example, Individual #74's ISP identified important outcomes that were not addressed in the CLDP, including learning how to tell time, operate his own television, and to initiate communication with his sister via technology (phone. facetime, etc.). While the CLDP did include a support to visit or call sister weekly, it provided no expectation for the type or level of staff support he would need to do so or for helping him learn how to initiate calls.

- Need/desire for employment, and/or other meaningful day activities: The CLDP did not meet criterion. Individual #74's CLDP included one post-move support that indicated he would attend day habilitation Monday through Friday. Another support (i.e., to participate in an outing once a month) only minimally addressed participation in meaningful day activities in any integrated community settings and did not meet criterion. His ISP identified some potentially meaningful and integrated opportunities that the IDT did not address in the CLDP (e.g., joining an art class in the community).

- Positive reinforcement, incentives, and/or other motivating components to an individual's success. The CLDP did not include any post-move supports in this area and did not meet criterion. However, the documentation provided for this review identified a number of opportunities. For example, his ISP and assessments noted that that Individual #74 displays self-injurious behavior when over prompted and that provider staff would need to build "rapport with Individual #74 to allow for smoother requests to do activities without resorting to self-injurious behavior as well as to minimize refusals in SAPs and daily routine." Provider staff could have benefited from this information to help Individual #74 adjust to his new living environment.

- Teaching, maintenance, participation, and acquisition of specific skills: The CLDP did not fully address the individual's needs in this area and did not meet criterion. It included one post-move support that indicated he would attend day habilitation Monday through Friday and would participate in arts and crafts as well as active treatment with flash cards to learn the numbers 1-20. As described above with regard to his important outcomes, based on his ISP and assessments, there were other opportunities for community-appropriate learning that included learning how to tell time, operate his own television, and place phone calls to his sister.

All recommendations from assessments are included, or if not, there is a rationale provided: As reported at the time of the previous review, the documentation of the IDTs' discussion of assessments and recommendations continued to need improvement. As described throughout this section, the CLDPs did not consistently ensure that recommendations from assessments were addressed and/or that the IDT provided a coherent rationale when recommendations were deferred or declined. Transition staff and disciplines should work together to ensure that both the source assessments and the corresponding CLDP summaries specifically highlight all important

recommendations and ensure that the CLDP includes the necessary post-move supports for implementation and post-move monitoring to occur.

Outcome 2 - Individuals are receiving the protections, supports, and services they are supposed to receive.											
Summary: Post-move monitoring continued to occur as often as needed. Some supports were not yet in place as called for the CLDP. The Monitoring Team attempted to observe a post-move monitoring visit, but some unavoidable delays at the Center and at the provider resulted in an incomplete observation. These indicators will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	74								
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% 0/1	0/1								
6	The PMM's assessment is correct based on the evidence.	0% 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.	Not rated	Attempted								
10	The PMM's report was an accurate reflection of the post-move monitoring visit.	Not rated	Attempted								

Comments:
5. Based on information the Post Move Monitor collected, the Monitoring Team could often not evaluate or confirm whether the individual had consistently received supports listed and/or described in the CLDP, due to the lack of reliable and valid data. The PMM's comments and evidence should address the full scope of needed supports. As described above with regard to the lack of measurability of some supports (i.e., in Indicator 1), as well as the lack of certain needed formal supports (i.e., in Indicator 2), the PMM comments were often not sufficient to reliably demonstrate that all needed supports were in place. The following provides additional examples of supports that were noted to not be in place at the time of the seven-day PMM visit:

- Provider staff did not have knowledge of supports for Individual #74 to call his sister, his PSP, or of his diet plan.
- Provider staff were not implementing his day habilitation program.

6. The PMM's scoring was often correct. In several instances, however, the PMM marked supports as in place, even when the available evidence at the time did not so indicate. In addition, the IDTs will need to continue to work to improve both the comprehensiveness and measurability of the supports, to support the accuracy of the PMM's work in this area.

9-10. Center staff had scheduled a PMM visit for the individual during the remote review. However, due to the late scheduling and some unavoidable delays that occurred during the visit itself, the Monitoring Team were only able to participate in a brief portion of that activity. As a result, these indicators were not rated. Based on this very limited observation, the PMM had a methodical approach to ensure she addressed each support. She also often requested additional evidence to corroborate what provider staff reported in interview. These were positive findings.

Outcome 3 – Supports are in place to minimize or eliminate the incidence of negative events following transition into the community.										
Summary: It was good to see that the individual had not had any negative events since his transition. This indicator will remain in active monitoring.			Individuals:							
#	Indicator	Overall Score	74							
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% 1/1	1/1							
Comments:										

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: The Center was working on improving transition assessments. The transition department should also attend to indicators 14-16 in future transition planning. These indicators will remain in active monitoring.			Individuals:							
#	Indicator	Overall Score	74							
12	Transition assessments are adequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting.	0% 0/1	0/1							

13	The CLDP or other transition documentation included documentation to show that (a) IDT members actively participated in the transition planning process, (b) The CLDP specified the SSLC staff responsible for transition actions, and the timeframes in which such actions are to be completed, and (c) The CLDP was reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Due to the Center's sustained performance, this indicator was moved to the category of requiring less oversight.									
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% 0/1	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% 0/1	0/1								
16	SSLC clinicians (e.g., OT/PT) complete assessment of settings as dictated by the individual's needs.	0% 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.	Due to the Center's sustained performance, these indicators were moved to the category of requiring less oversight.									
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.										
19	Pre-move supports were in place in the community settings on the day of the move.	0% 0/1	0/1								

Comments:

12. Assessments did not consistently meet criterion for this indicator, and this remained an area of need. The APC reported that transition staff were set to begin training with the individual disciplines to assist them in crafting needed and community-specific supports. The Monitoring Team considers the following four sub-indicators when evaluating compliance:

- Assessments updated with 45 Days of transition: The Center did not provide for review the updated BHA and FSA, which were dated approximately six months prior to the transition. The OT/PT and communication assessments did not provide a specific date of completion and the latest specific reference to the individual's status in the OT/PT assessment was dated in April 2021.
- Assessments provided a summary of relevant facts of the individual's stay at the facility: Missing assessments impacted the evaluation of this sub-indicator. In addition, IDTs still needed to ensure that assessments were comprehensive in scope and reflected current status. For example, the nursing assessment, updated 11/8/21, provided data for side effects monitoring (i.e., AIMS and MOSES) dated 5/21/21. At a minimum, the AIMS should have been updated at least once since that time.

- Assessments included a comprehensive set of recommendations setting forth the services and supports the individual needs to successfully transition to the community: Missing assessments impacted the evaluation of this sub-indicator. In addition, many assessments did not yet thoroughly provide specific and measurable recommendations to support transition.
- Assessments specifically address/focus on the new community home and day/work settings: Assessments did not fully address/focus on the new community home and day/work settings. Assessment recommendations varied considerably in comprehensiveness and individualization. As described with regard to Indicator 2 above, there were missed opportunities to make recommendations for community-specific skill acquisition and meaningful employment and community integration.

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: As described with regard to Indicator 1 above, training did not yet meet criterion for these two CLDPs. The Monitoring Team requested and reviewed the rosters and competency testing for all training provided related to these transitions, however, the Center did not make the training materials available for review. The CLDP pre-move training supports did not yet consistently identify the expected provider staff knowledge or competencies that would need to be demonstrated. In addition, competency testing did not clearly document provider staff had knowledge of all essential supports. The tests did not include questions for many supports, as also described with regard to Indicator 1 above.

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. This CLDP did not meet criterion. The CLDP stated Center nursing staff would complete a Nurse to Nurse collaboration on the day of move. The IDT further decided that the Provider Nurse could pass the information to the new PCP and a PCP to PCP was not needed. The IDT included two pre-move supports for this collaboration in the CLDP specifically to discuss results of ophthalmologist consult and any recommendations, as well as to review labs/diagnostic tests, medication he is currently taking, diagnoses or any pertinent medical history. However, the CLDP narrative noted two additional elements of the collaboration (i.e., provide supporting information to the community PCP/ PCP Nurse for the necessary medical referrals by the initial appointment and will provide the time frame of the upcoming appointments schedules) that were not included in the supports or had results summarized in the CLDP.

16. The IDT should describe in the CLDP whether any settings assessments are needed and/or describe any completed assessment of settings and the results, based on individual needs. The CLDP noted that Individual #74 did not need modifications to the home, nor to live in a certain environment (e.g., in a child free zone). However, based on the CLDP profile, his needs required a spacious home that would easily accommodate his wheelchair and a bathroom spacious to accommodate his 3:1 shower chair. At some point in the process, an appropriate Center staff person needed to confirm these requirements, which should have been documented.

19. The pre-move site review (PMSR) was completed prior to the transition date. However, it is essential the Center can directly affirm provider staff competency to ensure health and safety prior to relinquishing day-to-day responsibility, and the PMSR did not accomplish this. The CLDP pre-move supports for pre-move training did not meet criterion for ensuring that provider staff were competent for either individual, as described under Indicator 1 and Indicator 2. In addition, at the time of the PMSR, Center staff obtained evidence of competency testing only for the provider program manager and not for any of the direct support staff.

Outcome 5 – Individuals have timely transition planning and implementation.											
Summary: The Center engaged in activities on a regular basis to keep this transition moving forward. This indicator will remain in active monitoring.			Individuals:								
#	Indicator	Overall Score	74								
20	Individuals referred for community transition move to a community setting within 180 days of being referred, or reasonable justification is provided.	100% 1/1	1/1								

Comments:
20. This CLDP met criterion for this indicator. Individual #74 was referred on 9/12/18 and transitioned on 12/10/21. This exceeded 180 days, but the transition log indicated ongoing transition activity.