



Date: July 30, 2012

To: Kay Lilley, Director
Provider: Progressive Residential Services of NM, Inc.
Address: 250 S. Main, Ste A
State/Zip: Las Cruces, NM 88001

E-mail Address: klilley@prs-nm.org

Region: Southwest
Survey Date: May 14 - 16, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)

Survey Type: Routine
Team Leader: Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau.

Dear Ms. Lilley;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Determination of Compliance:

The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Partial Compliance with all Conditions of Participation.

This determination is based on your agency's partial compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Condition and Standard Level deficiencies identified and requires implementation of a Plan of Correction.

Plan of Correction:

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your



DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Progressive Residential Services of NM, Inc. – Southwest – May 14 - 16, 2012

Survey Report #: Q.12.4.DDW.D4244.3.001.RTN.1.212

agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. (See attachment "A" for additional guidance in completing the Plan of Correction).

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Request for Informal Reconsideration of Findings (IRF):

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-699-9356 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Mari Chavez, BSW

Mari Chavez, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	May 14, 2012
Present:	<u>Progressive Residential Services of NM, Inc.</u> Amy Herrera, Office Manager <u>DOH/DHI/QMB</u> Mari Chavez, BSW, Team Lead/Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor
Exit Conference Date:	May 16, 2012
Present:	<u>Progressive Residential Services of NM, Inc.</u> Kay Lilley, Director Lupe Wright, Licensed Practical Nurse Vicky Kingsby, Registered Nurse Irma Borunda, Staff Training Coordinator Rachel Guielfield, Chief Executive Officer/Allied (via telephone) Sue Yaguela, Compliance Officer/ Allied (via telephone) Yolanda Costales, Residential Service Coordinator Amy Herrera, Office Manager/Human Resource Support Chris Gomez, Service Coordinator Melissa Ortega, Billing and Payroll Irene Gonzales, Medical Assistant <u>DOH/DHI/QMB</u> Mari Chavez, BSW Team Lead/Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor <u>DDSD - Southwest Regional Office</u> Scott Doan, Regional Director
Total Homes Visited	Number: 7
❖ Supported Homes Visited	Number: 7
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 13 3 - <i>Jackson</i> Class Members 10 - Non- <i>Jackson</i> Class Members 8 - Supported Living 2 - Independent Living 8 - Adult Habilitation 3 - Community Access 4 - Supported Employment
Persons Served Records Reviewed	Number: 13
Persons Served Interviewed	Number: 3
Persons Served Observed	Number: 10 (5 Individuals were not available at the time of the on-site survey; 5 Individuals choose not to participate in interviews).

Direct Support Personnel Interviewed Number: 18

Direct Support Personnel Records Reviewed Number: 97

Service Coordinator Records Reviewed Number: 1

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes Evacuation Drills
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
 DOH - Developmental Disabilities Supports Division
 DOH - Office of Internal Audit
 HSD - Medical Assistance Division

Attachment A

Provider Instructions for Completing the QMB Plan of Correction (POC) Process

Introduction:

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days will be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. (Providers who fail to complete a POC within the 45 business days allowed shall be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-9356 or email at Crystal.Lopez-Beck@state.nm.us. Requests for technical assistance must be requested through your DDSD Regional Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

Instructions for Completing Agency POC:

Required Content

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction must address the required six CMS core elements to address each deficiency of the POC:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
 6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your POC:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

Note: Instruction or in-service of staff alone may not be a sufficient plan of correction. This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

Completion Dates

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
 - a. Electronically at Crystal.Lopez-Beck@state.nm.us (*preferred method*)
 - b. Fax to 505-222-8661, or
 - c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

- a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
 - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
 - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
 - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
 - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
 - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the POC Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

QMB Determinations of Compliance

- “Compliance with Conditions of Participation”
The QMB determination of “Compliance with Conditions of Participation,” indicates that a provider is in compliance with all ‘Conditions of Participation,’ (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.
- “Partial-Compliance with Conditions of Participation”
The QMB determination of “Partial-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) to three (3) ‘Conditions of Participation.’ This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Partial-Compliance’ for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Non-Compliant with Conditions of Participation”:
The QMB determination of “Non-Compliance with Conditions of Participation,” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
 - Four (4) Conditions of Participation out of compliance.
 - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
 - Any finding of actual harm or Immediate Jeopardy.The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

Providers receiving a repeat determination of ‘Non-Compliance’ will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

Attachment C

Guidelines for the Provider Informal Reconsideration of Finding (IRF) Process

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not made within 10 business days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

Agency: Progressive Residential Services of NM, Inc. - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: May 14 - 16, 2012

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Service Plans: ISP Implementation – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.			
Tag # 1A08 Agency Case File	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 8 of 13 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ None Found (#5, 6 & 11) • Annual ISP <ul style="list-style-type: none"> ◦ Not Found (#5 & 6) • ISP Signature Page (#5 & 6) • Individual Specific Training Section of ISP (formerly Addendum B) (#5 & 6) • ISP Teaching & Support Strategies <ul style="list-style-type: none"> ◦ <i>Individual #2 - TASS not found for the following Action Steps:</i> <ul style="list-style-type: none"> ➢ “Will work on project.” 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training</p>	<ul style="list-style-type: none"> ➤ "Will apply at place of his choice." ➤ "Will complete application." ➤ "Will save money for the event to purchase food or anything he might want." ➤ "Will attend event." <p>○ <i>Individual #5 - TASS not found for the following Action Steps:</i></p> <ul style="list-style-type: none"> ➤ "Will continue to go to take classes toward any degree until I graduate or find a government job." <p>○ <i>Individual #6 - TASS not found for the following Action Steps:</i></p> <ul style="list-style-type: none"> ➤ "Will go into the community twice a week to meet and develop various relationships with people in community for one year." <p>○ <i>Individual #8 - TASS not found for the following Action Steps:</i></p> <ul style="list-style-type: none"> ➤ "Complete interview process." ➤ "Transportation." ➤ "Purchase project." ➤ "Complete project." ➤ "Follow recommended nutrition plan." ➤ "Attend and participate in PT at SW Sport and Spine." <p>○ <i>Individual #10 - TASS not found for the following Action Steps:</i></p> <ul style="list-style-type: none"> ➤ "...will go to work." ➤ "...will utilize hip talker at each job site." <ul style="list-style-type: none"> ● Positive Behavioral Plan (#8) ● Positive Behavioral Crisis Plan (#9 & 10) ● Speech Therapy Plan (#6 & 13) 		
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<p>School or Ft. Stanton Hospital.</p> <p>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.</p> <p>B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.</p>	<ul style="list-style-type: none"> • Occupational Therapy Plan (#13) • Physical Therapy Plan (#6, 8 & 13) • Documentation of Guardianship/Power of Attorney (#5) • Annual Physical (#5, 6 & 11) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #11 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #11 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. 		
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<p>play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #10</p> <ul style="list-style-type: none"> • Per Relationships/Fun Outcome; Actions Steps for “Work on same project or medium for 4 consecutive weeks” is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency indicated in the ISP for 11/2011 - 3/2012. <p>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #2</p> <ul style="list-style-type: none"> • None found for 8/2011 - 11/2011 & 1/2012 - 4/2012 <p>Individual #7</p> <ul style="list-style-type: none"> • None found regarding: “...will work part time for the next year” for 8/2011 - 4/2012. <p>Individual #10</p> <ul style="list-style-type: none"> • None found for 7/2011 - 3/2012. <p>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #5</p> <ul style="list-style-type: none"> • None found for 3/2012. <p>Residential Files Reviewed:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p>		
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Individual #9

- Per Fun Outcome; Actions Steps for "...will invite others to review my scrapbook with me" is to be completed 1 time per week evidence found indicated it was not being completed at the required frequency indicated in the ISP for 5/2012.
- Per Fun Outcome; Actions Steps for "...will carry my scrapbook with me," is to be completed one time per week; evidence found indicated it was not being completed at the required frequency indicated in the ISP for the month of 5/2012.

<p>the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and</p> <p>(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.</p> <p>New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Policy Title: Vocational Assessment Profile Policy Eff July 16, 2008</p> <p>I. PURPOSE The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.</p> <p>II. POLICY STATEMENT Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.</p>			
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<p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated 	<ul style="list-style-type: none"> • Progress Notes written by Nurses regarding Health Status: <ul style="list-style-type: none"> ◦ Individual #4 - None found for 5/2012 ◦ Individual #13 - None found for 5/2012 		
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<p>copy must be placed in the agency file on a weekly basis.</p> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.</p>			
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Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</p> <ol style="list-style-type: none"> (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members. 	<p>Based on record review, the Agency failed to complete written quarterly status reports for 7 of 10 individuals receiving Community Living Services.</p> <p>Support Living Annual Assessment</p> <ul style="list-style-type: none"> • Individual #4 - None found for 7/2010-6/2011 • Individual #7 - None found for 8/2010 - 8/2011 • Individual #8 - None found for 7/2010 - 6/2011 • Individual #9 - None found for 1/2011-12/2012 • Individual #10 - None found for 7/2010-6/2011 <p>Independent Living Annual Assessment:</p> <ul style="list-style-type: none"> • Individual #2 - None found for 8/2010 - 7/2011 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:

- A. Individuals shall receive services from competent and qualified staff.
- B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
- C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
- D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
- E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.
- F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.
- G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.
- H. Staff shall complete and maintain certification in a DDSD-approved medication course in

accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</p> <p>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</p> <p>(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;</p> <p>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</p> <p>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on interview, the Agency failed to ensure that training competencies were met for 9 of 18 Direct Support Personnel.</p> <p>When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #77 stated, “No, he does not have one.” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #4) <p>When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #93 stated, “Watching his money.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. Review of the plan indicated the individual is currently working on communication and song recordings. (Individual #11) • DSP #93 stated, “No.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #5) • DSP #120 stated, “No.” According to the Health and Safety section of the Individual 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>individual;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDS in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDS Statewide Training Database as specified in DDS policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDS Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDS Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p>Department of Health (DOH) Developmental</p>	<p>ISP, the Individual requires a Speech Therapy Plan. (Individual #9)</p> <p>When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #92 stated, "Not at this time." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #8) <p>When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #92 stated, "Not at this time, the staff does this for her." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #8) <p>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #88 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration, Oral Care, Gastrointestinal (GI), and Falls. (Individual #10) • DSP #92 stated, "Didn't bring the medical book, basically everything in the medical book." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Gastrointestinal, Bowel and Bladder, Respiratory and Skin and Wound. (Individual 		
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<p>Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff.</p>	<p>#8)</p> <ul style="list-style-type: none"> • DSP #109 stated, for “blood pressure, keep him calm, Thorazine seems to worked a lot.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration, Seizure, Respiratory and Falls. (Individual #13) • DSP #134 stated, for “Allergies and Aspiration.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plans for Respiratory. (Individual #12) <p>When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #65 stated, “For seizures.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plans also for Aspiration. (Individual #2) • DSP #88 stated, “ All those are in the medical book at the house.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration, Gastrointestinal (GI) and Falls. Additionally, the Individual Specific Training section of the ISP indicates the Individual also requires Medical Emergency Response Plan for Allergies. (Individual #10) • DSP #92 stated, “Didn’t bring the medical book, basically everything’s in the medical 		
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	<p>book.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Asthma. Additionally, the Individual Specific Training section of the ISP indicates the Individual requires Medical Emergency Response Plans for Sleep Apnea, and Skin Breakdown. (Individual #8)</p> <ul style="list-style-type: none"> • DSP #134 stated, “I’d have to look at the book.” DSP was unable to refer to the agency file as the was left at the Day Hab. Nevertheless, the Electronic Comprehensive Health Assessment Tool indicates, the Individual requires Medical Emergency Response Plans for Aspiration and Respiratory (Individual #12) • DSP #129 stated, “Asthma and sleep apnea.” As indicated by the Individual Specific Training section of the ISP indicates the Individual requires Medical Emergency Response Plans for Skin breakdown. (Individual #8) • DSP #109 stated, “Yes, in case of medical crisis, not for anything specific.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration, Seizure, Respiratory, Falls and Continuous Positive Airway Pressure (C-Pap). (Individual #13) <p>When DSP were asked what the individual’s Diagnosis were, the following was reported:</p> <ul style="list-style-type: none"> • DSP #88 stated, “I don’t have them memorized.” According to the individuals ISP she is diagnosed with Phenylketonuria (PKU), 		
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	<p>Profound Mental Retardation, Anxiety, Agitation, Hearing Loss, Atopic Dermatitis, Osteoporosis, Osteoarthritis, Gastroesophageal Reflux Disease (GERD) and Tinea Pedis. Staff did not discuss the listed diagnosis. (Individual #10)</p> <p>When DSP were asked what do you do if there is high blood sugar regarding the Individual's Diabetes, the following was reported:</p> <ul style="list-style-type: none"> • DSP #77 stated, "Give him water, calm him down. I'm stuck on that one." (Individual #4) <p>When DSP were asked to describe what medications are prescribed for the individual, the following was reported:</p> <ul style="list-style-type: none"> • DSP #88 stated, "No, I don't. It's in her book." (Individual #10) 		
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Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency		
<p>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</p> <p>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</p> <p>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal</p>	<p>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 15 of 98 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> • #43 – Date of hire 8/10/2010 • #58 – Date of hire 3/17/2009 • #61 – Date of hire 9/6/2011 • #66 – Date of hire 9/6/2011 • #74 – Date of hire 12/29/2010 • #77 – Date of hire 9/6/2011 • #78 – Date of hire 2/9/2010 • #80 – Date of hire 2/20/2007 • #88 – Date of hire 8/3/2009 • #92 – Date of hire 9/6/2011 • #98 – Date of hire 8/10/2010 • #100 – Date of hire 8/30/2007 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p>E. crimes involving adult abuse, neglect or financial exploitation;</p> <p>F. crimes involving child abuse or neglect;</p> <p>G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p>H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>	<ul style="list-style-type: none"> • #131 – Date of hire 2/3/2009 • #133 – Date of hire 9/14/2007 <p>Service Coordination Personnel (SC):</p> <ul style="list-style-type: none"> • #137 – Date of hire 11/17/2010 		
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<p>documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide.</p> <p>F. Consequences of noncompliance. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1.IV. General Provider Requirements. D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and</p>			
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Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

competent and qualified staff.
C. Staff shall complete training on DOH-
approved incident reporting procedures in
accordance with 7 NMAC 1.13.

requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p>CMS Assurance – Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</p>			
<p>Tag # 1A03 CQI System</p>	<p>Standard Level Deficiency</p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health</p>	<p>Based on record review, the Agency failed to implement their Continuous Quality Management System as required by standard.</p> <p>The following was not found, not current and or incomplete:</p> <ul style="list-style-type: none"> • The Agency’s Continuous Quality Improvement Plan provided during the on-site survey (5/16/2012) was not dated. No evidence was found indicating when the document had been created or updated. Also, based on evidence found during the on-site survey and reflected in this report of findings the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>events;</p> <p>(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</p> <p>(6) Quality and completeness documentation; and</p> <p>(7) Trends in individual and guardian satisfaction.</p> <p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:</p> <p>(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;</p> <p>(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;</p> <p>(4) community based service providers</p>			
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<p>providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.</p>			
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<p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p> <p>(i) Name of resident;</p> <p>(ii) Date given;</p>	<ul style="list-style-type: none"> • Sodium Chloride 1GM (2 times daily) <p>May 2012 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Dilantin 100mg (1 time daily) – Blank 5/14 (8 PM) • Pepcid 20mg (1 time daily) – Blank 5/14 (8 PM) • Sodium Chloride 1GM (2 times daily) – Blank 5/14 (8 PM) • Risperidone 2mg (2 times daily) – Blank 5/14 (8 PM) • Flucinolone 0.01% (2 times daily) – Blank 5/14 (8PM) • Keppra 500mg (2 times daily) – Blank 5/14 (8 PM) • Neuroutin 400mg (3 times daily) – Blank 5/14 (8 PM) <p>Individual #4 May 2012 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> • Cetaphil Cleansing Lotion (1 time daily) – Blank 5/12 (8 AM) • Glipizide ER 5mg (1 time daily) – Blank 5/14 (8 AM) • Lisinpril 20mg (1 time daily) – Blank 5/14 (8 		
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<ul style="list-style-type: none"> (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. 	<p>AM)</p> <ul style="list-style-type: none"> • Lotrimin AF 2% Spray (1 time daily) – Blank 5/12 (8 AM) • Omeprazole 40mg (1 time daily) – Blank 5/14 (8 AM) • Plavix 75mg (1 time daily) – Blank 5/14 (8 AM) • Seroquel 100mg (1 time daily) – Blank 5/14 (8 AM) <p>Individual #8 March 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Prednisone 10mg (1 time daily) • Trazodone 150mg (2 times daily) <p>April 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Aspercreme CRM (3 times daily) • Haldol 1mg (2 times daily) • Trazodone 150mg (2 times daily) <p>May 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Trazodone 150mg (2 times daily) <p>Individual #9</p>		
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	<p>May 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Ibuprofen 200mg (2 times daily) • Rubbing Alcohol (1 time daily) <p>Individual #10 March 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Lamisil AT 1% cream (2 times daily) <p>April 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Neutrogena T/Gel Shampoo (2 times weekly) • Clobetasol 0.05% Solution (2 times weekly) <p>May 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Clobetasol 0.05% (2 times weekly) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • Senna Plus <p>Individual #12 March 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p>		
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	<ul style="list-style-type: none"> • Allegra 180 mg (1 time daily) <p>April 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Allegra 180mg (1 time daily) <p>Individual #13 April 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Carbanazepine 100mg (2 times daily) • R-Tanna (1 time daily) <p>Medication Administration Records did not contain the dosage for the following medications:</p> <ul style="list-style-type: none"> • R-Tanna <p>May 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> • Carbanazepine 100mg (2 times daily) 		
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<p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p>NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</p>	<ul style="list-style-type: none"> • Clonidine HCL 0.1%mg (PRN) <p>May 2012 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Trazadone 50mg – PRN – 5/9 & 10 (given 2 times) <p>Individual #8 May 2012 Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Triamcinolone 0.5% (PRN) <p>April 2012 Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Triamcinolone 0.5% (PRN) <p>Individual #10 May 2012 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</p> <ul style="list-style-type: none"> • Hydrocortizone 2.5% (PRN) <p>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Diazepam 5mg – PRN – 5/8 (given 1 time) <p>Individual #12 March 2012 Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Pro Air (PRN) 		
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<ul style="list-style-type: none"> (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. <p>Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> ➤ symptoms that indicate the use of the medication, ➤ exact dosage to be used, and ➤ the exact amount to be used in a 24 hour period. <p>Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006 F. PRN Medication 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure</p>	<p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Pro Air (PRN) <p>April 2012 Medication Administration Records did not contain the circumstance for which the medication is to be used:</p> <ul style="list-style-type: none"> • Pro Air (PRN) <p>Medication Administration Records did not contain the strength of the medication which is to be given:</p> <ul style="list-style-type: none"> • Pro Air (PRN) <p>May 2012 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</p> <ul style="list-style-type: none"> • Trazadone 50mg – PRN – 5/9 & 10 (given 2 times) 		
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<p>that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.</p> <p>4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).</p> <p>H. Agency Nurse Monitoring</p> <p>1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.</p>			
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<p>Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006</p> <p>C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).</p> <p>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.</p> <p>4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).</p>			
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Tag # 1A15.2 & 5I09 - Healthcare Documentation	Condition of Participation Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:</p> <ul style="list-style-type: none"> (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. <p>(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 9 of 13 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Electronic Health Assessment Tool (E-Chat) (#5, 6 & 11) • Medication Administration Assessment Tool (#5, 6, 11 & 13) • Healthcare Passport (#4, 5, 6, 8, 9 & 11) • Comprehensive Aspiration Risk Management Plan (#3) • Aspiration Risk Management Screening Tool (#4, 5, 6, 9 & 11) • Quarterly Nursing Review of HCP/Crisis Plans: <ul style="list-style-type: none"> ◦ None found for 7/2011 - 3/2012 (#4) ◦ None found for 7/2011 - 3/2012 (#8) ◦ None found for 4/2011 - 3/2012 (#10) • Health Care Plans <ul style="list-style-type: none"> • <i>Body Mass Index</i> ◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,</p>	<p>the individual is required to have a plan. No evidence of a plan found.</p> <ul style="list-style-type: none"> • Bowel and Bladder <ul style="list-style-type: none"> ◦ Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Gastrointestinal <ul style="list-style-type: none"> • Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #10 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Respiratory <ul style="list-style-type: none"> ◦ Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Crisis Plans/Medical Emergency Response Plans <ul style="list-style-type: none"> • Allergies <ul style="list-style-type: none"> ◦ Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #10 - As indicated by the IST section of ISP the individual is required to 		
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<p>method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain</p>	<p>have a plan. No evidence of a plan found.</p> <ul style="list-style-type: none"> • <i>Cardiac Condition</i> <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Gastrointestinal</i> <ul style="list-style-type: none"> ◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Respiratory</i> <ul style="list-style-type: none"> ◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. 		
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<p>a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.</p>			
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<p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p>(4) General Nursing Documentation</p> <p>(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.</p> <p>(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>B. IDT Coordination</p> <p>(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and</p> <p>(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.</p>			
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**Department of Health Developmental
Disabilities Supports Division Policy.
Medical Emergency Response Plan Policy
MERP-001 eff.8/1/2010**

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.

instructions for the completion and filing are available at the division's website, <http://dhi.health.state.nm.us/elibrary/ironline/ir.php> or may be obtained from the department by calling the toll free number.

<p>correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p> <p>(2) Division Incident Report Form and Notification by Community Based Service Providers: The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.</p>	<ul style="list-style-type: none"> • Incident date 7/29/2011 (3 PM). Type of incident identified was Neglect. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 5/17/2012 by DHI/QMB. <p>Individual #17</p> <ul style="list-style-type: none"> • Incident date 8/1/2011 (2 PM). Type of incident identified was Neglect. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 5/17/2012 by DHI/QMB. 		
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Tag # 1A29 Complaints / Grievances – Acknowledgement	Standard Level Deficiency		
<p>NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p>NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>NMAC 7.26.4.13 Complaint Process: A. (2). The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 4 of 13 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#3, 5, 6 & 11) 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>indicating the following information:</p> <ul style="list-style-type: none">a. dateb. time administeredc. name of patientd. dosee. practitioner's namef. signature of person administering or assisting with the administration the doseg. balance of controlled substance remaining.			
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<p>detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>	<ul style="list-style-type: none"> ◦ None found 7/2011 - 7/2012 for Haldol (#8) • Ear, Nose and Throat Exam <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by collateral documentation reviewed. The Primary Care Physician referred the Individual on 1/30/2012 to an Ear, Nose and Throat Specialist. No evidence of follow-up or exam was found. 		
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NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:

A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i>			
Tag # 5136 Community Access Reimbursement	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</p> <p>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ol style="list-style-type: none"> (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. <p>MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 3 individuals.</p> <p>Individual #11 February 2012</p> <ul style="list-style-type: none"> • The Agency billed 204 units of Community Access (H2021 U1) from 2/1/2012 through 2/29/2012. Documentation received accounted for 202 units. 	<p>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS G. Reimbursement (1) Billable Unit: A billable unit is defined as one-quarter hour of service.</p> <p>(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:</p> <ul style="list-style-type: none"> (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. <p>(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:</p> <ul style="list-style-type: none"> (a) Time and expense for training service 			
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<p>personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.</p>			
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<p>recoupment.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.</p> <p>B. Billable Activities</p> <p>(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours.</p> <p>(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours</p>	<p>Individual #13 February 2012</p> <ul style="list-style-type: none"> • The Agency billed 444 units of Adult Habilitation (T2021 U2 & U5) from 2/1/2012 through 2/29/2012. Documentation received accounted for 432 units. 		
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Date: September 26, 2012

To: Kay Lilley, Director
Provider: Progressive Residential Services of NM, Inc.
Address: 250 S. Main, Ste A
State/Zip: Las Cruces, NM 88001

E-mail Address: klilley@prs-nm.org

Region: Southwest
Survey Date: May 14 - 16, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Lilley;

Your request for a Reconsideration of Findings was received on August 13, 2012. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A20

QMB Report of Findings – Progressive Residential Services of NM, Inc. – Southwest – May 14 - 16, 2012

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the evidence received Person-Centered Planning for Staff #126 will be removed. The disputed citations for PCCM, R&A, PBSP and T&SS for Staff #129 and T&SS for Staff #131 will be upheld, as the training request form clearly shows the evidence of training was requested and there is no evidence of receipt of these documents. The remaining citations noted in tag 1A20 were not disputed.

Regarding Tag # 5144

Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the evidence supplied the citations for billing/reimbursement for the following will be removed.

- Individual #3 – January and February 2012
- Individual #12 – March 2012
- Individual #13 – February 2012

The remaining citations noted in tag 1A20 were not disputed.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,

Scott Good
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

SUSANA MARTINEZ, GOVERNOR



BRAD McGRATH, INTERIM SECRETARY

Date: October 18, 2012

To: Kay Lilley, Director
Provider: Progressive Residential Services of NM, Inc.
Address: 250 S. Main, Ste A
State/Zip: Las Cruces, NM 88001

E-mail Address: klilley@prs-nm.org

Region: Southwest
Survey Date: May 14 - 16, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine

Dear Ms. Lilley:

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

The Quality Management Bureau will need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

QMB Report of Findings – Progressive Residential Services of NM, Inc. – Southwest – May 14 - 16, 2012

Survey Report #: Q.12.4.DDW.D4244.3.001.RTN.1. 212

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, your case will be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions

Thank you for your cooperation with the Plan of Correction process.

Sincerely,



Crystal Lopez-Beck
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.13.2.DDW.D4244.3.001.RTN.07.292