
Date: February 1, 2013

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

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

Region: Southwest
Routine Survey: May 14 - 16, 2012
Verification Survey: December 5 - 6, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)

Survey Type: Verification

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

Team Members: Amanda Castaneda, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Lilley;

The Division of Health Improvement/Quality Management Bureau has completed a Verification Survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the Routine Survey on May 14 - 16, 2012, as well as your Plan of Correction regarding the IRC actions related to Individual Funds. The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Compliance with Conditions of Participation

However due to the new/repeat deficiencies your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator at 505-699-9356, if you have questions about the survey or the report.

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



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

Survey Process Employed:

Entrance Conference Date:	12/5/2012
Present:	<u>Progressive Residential Services of New Mexico, Inc.</u> Kay Lilley, Director <u>DOH/DHI/QMB</u> Mari Chavez, BSW, Team Lead/Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor
Exit Conference Date:	12/6/2012
Present:	<u>Progressive Residential Services of New Mexico, Inc.</u> Kay Lilley, Director Yolanda Costales, Service Coordinator Heather Gilbert, LPN Health Service Coordinator Brittany Glenn, RN Clinical Supervisor Chris Gomez, Program Liaison Irene Gonzales, Medical Assistant Melissa Ortega, Billing/Payroll Specialist <u>DOH/DHI/QMB</u> Mari Chavez, BSW Team Lead/Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor <u>DDSD - Southwest Regional Office</u> Zack Robinson, Social & Community Services Coordinator
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 13 3 - <i>Jackson</i> Class Members 10 - <i>Non-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
Direct Support Personnel Interviewed	Number: 13
Direct Support Personnel Records Reviewed	Number: 89
Service Coordinator Records Reviewed	Number: 1
Administrative Files Reviewed	<ul style="list-style-type: none">• 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 B

Department of Health, Division of Health Improvement QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on the provider's compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in three (3) Service Domains.

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare & Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

CoPs and Service Domains for Case Management Supports are as follows:

Service Domain: Level of Care

Condition of Participation:

1. **Level of Care:** The Case Manager shall complete all required elements of the Long Term Care Assessment Abstract (LTCAA) to ensure ongoing eligibility for waiver services.

Service Domain: Plan of Care

Condition of Participation:

2. **Individual Service Plan (ISP) Creation and Development:** Each individual shall have an ISP. The ISP shall be developed in accordance with DDSD regulations and standards and is updated at least annually or when warranted by changes in the individual's needs.

Condition of Participation:

3. **ISP Monitoring and Evaluation:** The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

CoPs and Service Domain for ALL Service Providers is as follows:

Service Domain: Qualified Providers

Condition of Participation:

4. **Qualified Providers:** Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.

CoPs and Service Domains for Living Supports and Inclusion Supports are as follows:

Service Domain: Plan of Care

Condition of Participation:

5. **ISP Implementation:** Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

Service Domain: Health, Welfare & Safety

Condition of Participation:

6. **Individual Health, Safety and Welfare: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

7. **Individual Health, Safety and Welfare (Healthcare Oversight):** The provider shall support individuals to access needed healthcare services in a timely manner. Nursing, healthcare services and healthcare oversight shall be available and provided as needed to address individuals' health, safety and welfare.

QMB Compliance Determinations

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). 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 in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

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 Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. 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) in any of the Service Domains.

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Non-Compliance 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 in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-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) in any of the Service Domains

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 or sanctions.

**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 New Mexico, Inc. - Southwest Region
Program: Developmental Disabilities Waiver
Service: Community Living Supports (Supported Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Monitoring Type: Verification Survey
Routine Survey: May 14 - 16, 2012
Verification Survey: December 5 - 6, 2012

Standard of Care	Routine Survey May 14 – 16, 2012 Deficiencies	Verification Survey December 5 - 6, 2012 New and Repeat Deficiencies
<i>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.</i>		
Tag # 1A32 & 6L14 ISP Implementation	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division</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 implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 6 of 13 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> Per Live Outcome; Actions Steps for "...will 	<p>New/Repeat Finding:</p> <p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 6 of 13 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #3</p> <ul style="list-style-type: none"> "...will research where to go" is to be completed 2 times per month. Outcome/Action Step was not being completed at the required frequency for 11/2012.

<p>and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and 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>prepare healthy/balanced meal” is to be completed “gradually to 5 times per week from 2 times per week” evidence found indicated it was not being completed at the required frequency indicated in the ISP for 11/2011 - 3/2012.</p> <p>Individual #2</p> <ul style="list-style-type: none"> • None found regarding: “Will work on my project” for 12/2011 - 1/2012. • None found regarding: “Will research events” for 12/2011 - 1/2012. • None found regarding: “Will save money” for 12/2011 - 1/2012. <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 #12</p> <ul style="list-style-type: none"> • Per Live Outcome: Action Step for “...will pick a task,” is to be completed 1 time daily, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/11/2012 & 11/30/2012. • Per Live Outcome; Action Step for “...will complete a task,” is to be completed 1 time daily, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/11/2012 and 11/30/2012. <p>Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • None found regarding: “I will self initiate my cleaning schedule...will follow cleaning schedule” for 11/2012. <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 Relationship/Fun Outcome: Action Step for “... will attend the program,” is to be completed 1 time daily, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 11/2012. <p>Individual #12</p> <ul style="list-style-type: none"> • Per Relationships/Fun Outcome: Action Step for “work on project,” is to be completed 1 time weekly, evidence found indicated it was not being completed at the required frequency as
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	<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> <p>Individual #9</p> <ul style="list-style-type: none"> • 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>indicated in the ISP for 10/2012 - 11/2012.</p> <p>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • None found regarding: "...will go to places in the community to learn about plants and herbs," for 10/2012 - 11/2012. <p>Individual #5</p> <ul style="list-style-type: none"> • Per Relationship/ Fun Outcome: Action Step for "Invite a friend to a planned activity," is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2012 - 11/2012. <p>Individual #7</p> <ul style="list-style-type: none"> • Per Live Outcome; Action Step for "...will care for his pet," is to be completed 1 time daily, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 11/2012. <p>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #10</p> <ul style="list-style-type: none"> • Per Work/Learn Outcome: Action Step for "...will go to work," is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012. • Per Work/Learn Outcome: Action Step for "...will utilize hip talker at each job site," is to be completed 2 times per week, evidence found indicated it was not being completed at the
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		required frequency as indicated in the ISP for 10/2012 - 11/2012.
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Standard of Care	Routine Survey May 14 – 16, 2012 Deficiencies	Verification Survey December 5 - 6, 2012 New and Repeat Deficiencies
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.		
Tag # 1A15.2 & 5I09 - Healthcare Documentation	Condition of Participation Level Deficiency	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 - 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</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 individuals.</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) 	<p>New/Repeat Finding:</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 13 individuals.</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Electronic Comprehensive Health Assessment Tool (eChat) (#6) • Medication Administration Assessment Tool (#6) • Aspiration Risk Screening Tool (#6) • Health Care Plans <ul style="list-style-type: none"> • <i>Weight/Body Mass Index</i> Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Medical Emergency Response Plans <ul style="list-style-type: none"> • <i>Allergies</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.

<p>the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these 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</p>	<ul style="list-style-type: none"> ◦ None found for 7/2011 - 3/2012 (#8) ◦ None found for 4/2011 - 3/2012 (#10) <p>• Health Care Plans</p> <ul style="list-style-type: none"> • <i>Body Mass Index</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. • <i>Bowel and Bladder</i> <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. • <i>Gastrointestinal</i> <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. • <i>Respiratory</i> <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. <p>• Crisis Plans/Medical Emergency Response</p>	<ul style="list-style-type: none"> • <i>Hypothyroidism</i> <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
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<p>examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, 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</p>	<p>Plans</p> <ul style="list-style-type: none"> • <i>Allergies</i> <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 have a plan. No evidence of a plan found. • <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>for the individual to maintain 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> <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>		
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(4) General Nursing Documentation

(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.

(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.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

(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

(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.

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010

<p>F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:</p> <ol style="list-style-type: none">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.		
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Tag # 1A27 Incident Mgt Late & Failure to Report	Standard Level Deficiency	Standard Level Deficiency
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</p> <p>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written 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,</p>	<p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 3 of 13 individuals.</p> <p>Individual #7</p> <ul style="list-style-type: none"> Incident date 8/7/2011. Allegation was Emergency Services. Incident report was received 8/10/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Incident date 1/24/2012. Allegation was Abuse. Incident report was received 1/27/2012. Late Reporting. IMB Late & Failure Report indicated incident of Abuse was "Confirmed." <p>Individual #13</p> <ul style="list-style-type: none"> Incident date 2/7/2012. Allegation was Neglect. Incident report was received 2/7/2012. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #15</p> <ul style="list-style-type: none"> Incident date 3/19/2012. Allegation was Neglect. Incident report was received 3/22/2012. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." 	<p>New/Repeat Finding:</p> <p>Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 2 of 18 individuals.</p> <p>Individual #16</p> <ul style="list-style-type: none"> Incident date 7/15/2011. Allegation was Neglect. Incident report was received 5/17/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." Incident date 7/29/2011. Allegation was Neglect. Incident report was received 5/17/2012. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #18</p> <ul style="list-style-type: none"> Incident date 6/10/2012. Allegation was Emergency Services. Incident report was received 6/22/2010. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."

<http://dhi.health.state.nm.us/elibrary/ironline/ir.php>
or may be obtained from the department by calling
the toll free number.

Standard of Care	Routine Survey May 14 – 16, 2012 Deficiencies	Verification Survey December 5 - 6, 2012 New and Repeat Deficiencies
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	Completed
Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency	Completed
Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency	Completed
Tag # 5I22 SE Agency Case File	Standard Level Deficiency	Completed
Tag # 6L14 Residential Case File	Standard Level Deficiency	Completed
Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Standard Level Deficiency	Completed
CMS Assurance – Qualified Providers – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.		
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	Completed
Tag # 1A22 Agency Personnel Competency	<i>Condition of Participation Level Deficiency</i>	Completed
Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency	Completed
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency	Completed
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Completed
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	Completed
CMS Assurance – Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of		

<i>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.</i>		
Tag # 1A03 CQI System	Standard Level Deficiency	Completed
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency	Completed
Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency	Completed
Tag # 1A27.2 Duty to Report - IR's Filed During On-Site and/or IR's Not Reported by Provider	Standard Level Deficiency	Completed
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency	Completed
Tag # 1A29 Complaints / Grievances – Acknowledgement	Standard Level Deficiency	Completed
Tag # 1A33 Board of Pharmacy - Med Storage	Standard Level Deficiency	Completed
Tag # 1A33.1 Board of Pharmacy - Lic	Standard Level Deficiency	Completed
Tag # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency	Completed
Tag # 6L25 Residential Health & Safety (Supported Living)	Standard Level Deficiency	Completed
CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.		
Tag # 5I36 Community Access Reimbursement	Standard Level Deficiency	Completed
Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency	Completed

Date: December 17, 2013

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

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

Region: Southwest
Routine Survey: May 14 - 16, 2012
Verification Survey: December 5 - 6, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Independent Living) and
Community Inclusion Supports (Adult Habilitation, Community Access,
Supported Employment)

Survey Type: Verification

Dear Ms. Lilley;

You have completed all the requirements per the Internal Review Committee (IRC).

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,



Crystal Lopez-Beck
Deputy Bureau Chief
Quality Management Bureau/DHI

Q.14.2.DDW.D4244.4.001.VER.09.351