Date: May 14, 2013
To: Pam Lillibridge, Chief Executive Officer
Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, New Mexico 88004
E-mail Address: plillibridge@trescomail.org
Region: Southwest
Survey Date: April 29 – May 2, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Focused
Team Leader: Cynthia Nielsen, MSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Corrina Strain, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Valerie V. Valdez, M.S., Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau; Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Margaret Pell, B.A., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Deb Russell, B.S., Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau; Anthony Vincent, RN, Department of Health/Developmental Disabilities Supports Division.

Dear Ms. Lillibridge;

The Division of Health Improvement/Quality Management Bureau and the Developmental Disabilities Supports Division have completed a focused survey requested by the Internal Review Committee 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. The specific focus of the survey was to determine compliance with healthcare, safety and medical oversight, as well as, the implementation of your IRC Directed Corrective Action. This Report of Findings will be shared with the Developmental Disabilities Supports Division and the Internal Review Committee for their use in determining your current and future provider contracts. 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:

**Compliance with all Conditions of Participation.**

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**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](http://www.dhi.health.state.nm.us)

QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013
Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134
This determination is based on your agency’s compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates 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 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,

Valerie V. Valdez, M.S.

Valerie V. Valdez, M.S.

QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013

Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134
Survey Process Employed:

Entrance Conference Date: April 29, 2013

Present:

**Tresco, Inc.**
Pam Lillibridge, Chief Executive Officer
Thelma Cedillo, BS, RN, Clinical Coordinator

**DOH/DHI/QMB**
Cynthia Nielsen, MSN, RN, Team Lead/Healthcare Surveyor
Corrina Strain, RN, Healthcare Surveyor
Valerie V. Valdez, M.S., Healthcare Program Manager
Nadine Romero, LBSW, Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor
Margaret Pell, B.A., Healthcare Surveyor
Deb Russell, B.S., Healthcare Surveyor
Scott Good, MRC, CRC, Deputy Bureau Chief

**DDSD - Metro Regional Office**
Anthony Vincent, RN

Exit Conference Date: May 1, 2013

Present:

**Tresco, Inc.**
Pam Lillibridge, Chief Executive Officer
Dona Martinez, CLS Program Manager
Gail Estell, Human Resource Manager
Nicole Johnson, Quality Enhancement Systems Manager
Virginia Valenzuela, Data Specialist, Document Coordinator
Al Sanchez, Vocational Service Manager
Maureen Gant, Program Supports Manager

**DOH/DHI/QMB**
Cynthia Nielsen, MSN, RN, Team Lead/Healthcare Surveyor
Corrina Strain, RN, Healthcare Surveyor
Valerie V. Valdez, M.S., Healthcare Program Manager
Nadine Romero, LBSW, Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor
Margaret Pell, B.A., Healthcare Surveyor
Deb Russell, B.S., Healthcare Surveyor
Scott Good, MRC, CRC, Deputy Bureau Chief
Dan Maxwell, M.S, DHI Deputy Director (via telephone)

**DDSD - Southwest Regional Office**
Scott Doan, Regional Manager

Administrative Locations Visited

Number: 1

Total Sample Size

Number: 20
6 - Jackson Class Members
14 - Non-Jackson Class Members
19 - Supported Living
16 - Adult Habilitation
2 - Supported Employment
<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Homes Visited</td>
<td>12</td>
</tr>
<tr>
<td>Supported Living Homes Visited</td>
<td>12</td>
</tr>
<tr>
<td>Persons Served RecordsReviewed</td>
<td>20</td>
</tr>
<tr>
<td>Persons Served Interviewed</td>
<td>7</td>
</tr>
<tr>
<td>Persons Served Observed</td>
<td>13</td>
</tr>
<tr>
<td>(4 Individuals did not want to participate in interview process; Surveyors were unable to understand the responses of 2 Individuals; 2 Individuals would not respond to Surveyors; 4 Individuals were involved in their routine and Surveyors did not want to disrupt the activity and 1 Individual was not available during the on-site visit)</td>
<td></td>
</tr>
<tr>
<td>Direct Support Personnel Interviewed</td>
<td>15</td>
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<tr>
<td>Direct Support Personnel Records Reviewed</td>
<td>201</td>
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<tr>
<td>Service Coordinator Records Reviewed</td>
<td>5</td>
</tr>
<tr>
<td>Nursing Personnel and Medical Support I</td>
<td>9</td>
</tr>
</tbody>
</table>

Administrative Processes and Records Reviewed:

- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- 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
- DOH - Internal Review Committee
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 NE, 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 Deputy Chief at QMB, 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.
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 provider 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 and 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 and 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 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). 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.
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 received 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 written 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 received 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.
**Standard of Care** | **Deficiencies** | **Agency Plan of Correction, On-going QA/QI and Responsible Party** | **Date Due**
---|---|---|---

**Service Domain: 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.

<table>
<thead>
<tr>
<th>Tag # 1A08</th>
<th>Service Plans: ISP Implementation</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Agency Case File</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>

**Tag # 1A08**

Agency Case File


**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.

**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:

1. Emergency contact information, including the individual’s address, telephone number,

Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 20 individuals.

Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:

- Speech Therapy Plan (#17)

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →


(1) 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;

(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);

(3) Progress notes and other service delivery documentation;

(4) Crisis Prevention/Intervention Plans, if there are any for the individual;

(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;

(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

(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.

(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:

   (a) Complete file for the past 12 months;

   (b) ISP and quarterly reports from the current and prior ISP year;

   (c) Intake information from original admission to services; and

   (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.
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.
## Tag # 1A32 and 6L14
### Individual Service Plan Implementation

<table>
<thead>
<tr>
<th>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.</th>
<th>Based on record review, the Agency did not 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 1 of 20 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: Residential Files Reviewed: Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #8 • None found regarding: &quot;...will feed the bird or fish for 4/1 – 29, 2013. Action Step to be completed 1 time weekly.</th>
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<tbody>
<tr>
<td>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 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.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td></td>
</tr>
</tbody>
</table>

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QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013

Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134
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]
### Tag # 6L14
#### Residential Case File


**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**

**A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual’s home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual’s home, the complete and current confidential case file for each individual shall be maintained at the agency’s administrative site. Each file shall include the following:

1. Complete and current ISP and all supplemental plans specific to the individual;
2. Complete and current Health Assessment Tool;
3. Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician’s name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;
4. Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
5. Data collected to document ISP Action Plan implementation

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 8 of 19 Individuals receiving Supported Living Services.</td>
<td></td>
</tr>
</tbody>
</table>

Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:

- Annual ISP (#16)
- Individual Specific Training Section of ISP (#16)
- Positive Behavioral Plan (#1)
- Speech Therapy Plan (#10, 13)
- Occupational Therapy Plan (#3)
- Physical Therapy Plan (#16)
- **Special Health Care Needs**
  - Nutritional Plan (#3, 5, 16)
  - Comprehensive Aspiration Risk Management Plan (#3)
- **Health Care Plans**
  - Bowel and Bladder (#6)
  - Oral Care (#15)
  - Respiratory (#3)
  - Tube Feeding (#3)
- **Medical Emergency Response Plans**
  - Tube Feeding (#3, 10)

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
(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;

(7) Physician’s or qualified health care providers written orders;

(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);

(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (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:
       (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
copy must be placed in the agency file on a weekly basis.
(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
(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.
### Service Domain – 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.

<table>
<thead>
<tr>
<th>Tag # 1A20 Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency did not ensure Orientation and Training requirements were met for 1 of 201 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:  
  - First Aid (DSP #50)  
  - CPR (DSP #50) | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → | |
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.
<table>
<thead>
<tr>
<th>Tag # 1A22 Agency Personnel Competency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on interview, the Agency did not ensure training competencies were met for 2 of 15 Direct Support Personnel.</td>
</tr>
<tr>
<td>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.</td>
<td>When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:</td>
</tr>
<tr>
<td>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:</td>
<td>• DSP #89 stated, “I’m not sure because she comes during the day from 8 – 4 and I work 4 to 8 am.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #4)</td>
</tr>
<tr>
<td>(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;</td>
<td>• DSP #89 stated, “I’m not sure because they come when I am not here from 8 to 4.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #12)</td>
</tr>
<tr>
<td>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</td>
<td>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</td>
</tr>
<tr>
<td>(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 individual;</td>
<td>• DSP #240 stated, &quot;Aspiration, tube feeding, self abuse, physical movement, skin integrity, nutrition, ineffective breathing, that’s it.&quot; As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Oral Care and Falls (Individual #10)</td>
</tr>
<tr>
<td></td>
<td>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:</td>
</tr>
</tbody>
</table>

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

(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.

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:
   (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;
   (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and
   (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

<table>
<thead>
<tr>
<th>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>- DSP #89 stated, “Seizures, constipation and high blood pressure.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for reflux. (Individual #4)</td>
</tr>
</tbody>
</table>
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.
Service Domain: 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 # 1A09  
Medication Delivery  
Routine Medication Administration

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Delivery</td>
<td>Routine Medication Administration</td>
<td>Medication Administration Records (MAR) were reviewed for the months of February, March and April 2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on record review, 11 of 19 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Individual #3</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>February 2013</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Medication Administration Records contain the following medications:</td>
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<tr>
<td></td>
<td></td>
<td>• Levaquin 500mg (1 time daily for 3 days).</td>
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<td></td>
<td></td>
<td>• Bactrim dm (2 times daily for 7 days).</td>
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<tr>
<td></td>
<td></td>
<td>• Levofloxacim 500mg (1 time daily for 3 days).</td>
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<td></td>
<td></td>
<td>March 2013</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
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<tr>
<td></td>
<td></td>
<td>• Miralax (2 times daily)</td>
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<tr>
<td></td>
<td></td>
<td>Medication Administration Records contain the following medications. No Physician’s Orders were found for the following</td>
<td></td>
</tr>
</tbody>
</table>

Provider:
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →


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.

E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and
generic name of the medication, diagnosis for which the medication is prescribed;
(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(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.
(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;
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
(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 administrating the medication, signs and symptoms of adverse events and interactions with other medications;

**NMAC 16.19.11.8 MINIMUM STANDARDS:**
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:
(d) The facility shall have a Medication

medications:
- Amoxicillin 500mg (3 times daily for 8 days).
- Cipro 500mg (2 times daily for 5 days).

April 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Cipro 500mg (2 times daily for 5 days).

Individual #4
February 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Lisinopril 20mg (1 time daily)
- Cephalexin 500mg (3 times daily)
- Patanol 0.1% (3 times daily)

March 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Cephalexin 500mg (3 times daily)
- Patanol 0.1% (3 times daily)

Individual #5
February 2013
As indicated by the Medication Administration Records the individual is taking Dyazide (triamterene-hydrochlorothiazid) 37.5 – 25mg (PRN). According to the Physician’s Orders, Dyazide (triamterene-hydrochlorothiazid) 37.5
Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:

(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.

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.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- 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.

- 25mg is to be taken 1 time daily, and “prn swelling, or systolic bp 140.” Medication Administration Record and Physician’s Orders do not match.

March 2013
As indicated by the Medication Administration Records the individual is taking Dyazide (triamterene-hydochlorothiazid) 37.5 – 25mg (PRN). According to the Physician’s Orders, Dyazide (triamterene-hydochlorothiazid) 37.5 – 25mg is to be taken 1 time daily, and “prn swelling, or systolic bp 140.” Medication Administration Record and Physician’s Orders do not match.

Individual #7
February 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Keppra 500mg (3 times daily) – Blank 2/28 (10 PM)

Medicating Administration Record indicates Betamethasone .05% ointment was discounted on 12/27/2012. MAR indicates medication was assisted with on 3/1 (8AM).

Individual #10
February 2013
Medication Administration Records indicates “take 2 Tablespoons everyday mixed with water via g-tube.” MAR does not indicate how much water is to be added to the following medications:
- Miralax Powder (1 time daily)

March 2013
Medication Administration Records indicates “take 2 Tablespoons everyday mixed with water via g-tube.” MAR does not indicate how much water is to be added to the following medications:
- Miralax Powder (1 time daily)
water via g-tube.” MAR does not indicate how much water is to be added to the following medications:
  • Miralax Powder (1 time daily)

Individual #11
February 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
  • Coumadin 2.5 mg (1 time from 2/20 – 2/28)

March 2013
As indicated by the Medication Administration Records the individual is taking Risperdal 3mg 1 tablet (2 times daily). According to the Physician’s Orders Risperdal 3mg 1/2 tablet is to be taken 2 times daily. Medication Administration Record and Physician’s Orders do not match.

Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
  • Coumadin 7.5 mg (1 time on 3/25)
  • Coumadin 2.5 mg (1 time Sundays, Tuesdays, Wednesdays, Thursdays and Saturdays)
  • Lovenox 70mg (2 times daily for 5 days)

Individual #12
February 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
  • Depakote Sprinkles 125mg (3 caps at noon)
• Depakote Sprinkles 125mg (2 times daily 6 cap in morning; 6 caps in evening)

Individual #14
April 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
• Amlactin 12% Lotion (1 times daily) – Blank 4/24 (8PM)

• Nyastatin (3 times weekly) – Blank 4/24.

Individual #15
March 2013
As indicated by the Medication Administration Records the individual is taking Klor-Con 20meq (2 times daily). According to the Physician's Orders Klor-Con 20meq orders changed on 3/25/2013 to 1 time daily. Medication Administration Record and Physician’s Orders do not match. Review of MAR indicates Individual received medication 2 times daily from 3/26 – 31.

Individual #16
February 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
• Dyazide 37.5 – 25mg (3 times weekly)

• Lovaquin (Levothaxacin) 750mg (1 time daily for 8 days)

As indicated by the Medication Administration Records the individual is to take CVS Saline Nasal Spray.65% SOLN (3 times daily) and also PRN Nasal Congestion. According to the
Physician’s Orders CVS Saline Nasal Spray .65% SOLN is to be taken 3 times daily.
Medication Administration Record and Physician’s Orders do not match.

Individual #17
February 2013
As indicated by the Medication Administration Records the individual is to take Celebrex 200mg (1 time daily). According to the Physician’s Orders Celebrex 200mg is to be taken every other day. Medication Administration Record and Physician’s Orders do not match.

As indicated by the Medication Administration Records the individual is to take Requip 1mg (1 time daily). Medication Administration Record additionally indicates medication was discontinued. No orders found indicating date it was discontinued.

March 2013
As indicated by the Medication Administration Records the individual is to take Celebrex 200mg (1 time daily). According to the Physician’s Orders Celebrex 200mg is to be taken every other day. Medication Administration Record and Physician’s Orders do not match.

As indicated by the Medication Administration Records the individual is to take Requip 1mg (1 time daily). Medication Administration Record additionally indicates medication was discontinued. No orders found indicating date it was discontinued.
<table>
<thead>
<tr>
<th>Tag # 1A09.1</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Delivery PRN Medication Administration</td>
<td>Medication Administration Records (MAR) were reviewed for the months of February, March and April 2013. Based on record review, 9 of 19 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #1 February 2013 Medication Administration Records contain the following medications: • Docusate 100mg (PRN) • First Aid Cream (PRN) • Guiatuss (Robitussin) (PRN) • Ibuprofen 200mg (PRN) • Pepto Bismol 30 – 60 mls (PRN) • Murine/Visine (PRN) • Sun Screen (PRN) As indicated by the Medication Administration Records the individual is to take Benadryl (PRN) for allergies. According to the “MAR Comments Sheet,” Benadryl was given 1 time on 2/19/2013 for “vomiting, upset stomach.” “MAR Comments Sheet” indicates medication was not given for the purpose that it was ordered.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>


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.

E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;

(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
(c) Initials of the individual administering or assisting with the medication;  
(d) Explanation of any medication irregularity;  
(e) Documentation of any allergic reaction or adverse medication effect; and  
(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.

(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;  
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;  
(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;

NMAC 16.19.11.8 MINIMUM STANDARDS:  
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:  
(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:

```
March 2013  
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:  
• Benadryl (PRN)  
• Docusate 100mg (PRN)  
• First Aid Cream (PRN)  
• Guiatuss (Robitussin) (PRN)  
• Ibuprofen 200mg (PRN)  
• Pepto Bismol 30 – 60 mls (PRN)  
• Murine/Visine (PRN)  
• Sun Screen (PRN)

Individual #3  
February 2013  
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:  
• Docusate 100mg (PRN)  
• First Aid Cream (PRN)  
• Ibuprofen Oral Suspension 100mg/5ml (PRN)  
• Levaquin 500mg (PRN 3 days)

As indicated by the Medication Administration Records the individual is to take Imodium 2mg (PRN) “Not to exceed 8 capsules in 24 hours.” According to the Physician’s Orders, Imodium
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QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013  
Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134
(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;

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.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- 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.

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

2mg (PRN) is “Not to exceed 4 tabs in 24 hours.” Medication Administration Record and Physician’s Orders do not match.

March 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- First Aid Cream (PRN)
- Ibuprofen Oral Suspension 100mg/5ml (PRN)

As indicated by the Medication Administration Records the individual is to take Imodium 2mg (PRN) “Not to exceed 8 capsules in 24 hours.” According to the Physician’s Orders, Imodium 2mg (PRN) is “Not to exceed 4 tabs in 24 hours.” Medication Administration Record and Physician’s Orders do not match.

Individual #4
February 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Pink Bismuth/Pepto Bismol (PRN)
- Murine/Visine (PRN)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

March 2013
Medication Administration Records contain
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.

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).

H. Agency Nurse Monitoring
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.

the following medications. No Physician’s Orders were found for the following medications:

- Pink Bismuth/Pepto Bismol (PRN)
- Murine/Visine (PRN)

Individual #5
February 2013
As indicated by the Medication Administration Records the individual is taking Dyazide (triamterene-hydrochlorothiazid) 37.5 – 25mg (PRN). According to the Physician’s Orders, Dyazide (triamterene-hydrochlorothiazid) 37.5 – 25mg is to be taken 1 time daily, and “prn swelling, or systolic bp 140.” Medication Administration Record and Physician’s Orders do not match.

March 2013
As indicated by the Medication Administration Records the individual is taking Dyazide (triamterene-hydrochlorothiazid) 37.5 – 25mg (PRN). According to the Physician’s Orders, Dyazide (triamterene-hydrochlorothiazid) 37.5 – 25mg is to be taken 1 time daily, and “prn swelling, or systolic bp 140.” Medication Administration Record and Physician’s Orders do not match.

Individual #6
February 2013
Medication Administration Records contain the following medications. Physician’s Orders indicate medication “remove.” No discontinued date is noted for the following medication:
- Tylenol Arthritis 650mg (PRN)

March 2013
Medication Administration Records contain
### Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery

**Procedure Eff Date:** November 1, 2006

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).

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

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.).

<table>
<thead>
<tr>
<th>Individual</th>
<th>Date</th>
<th>Observations</th>
</tr>
</thead>
</table>
| #9         | February 2013 | Medication Administration Records did not contain the dosage of the medication which is to be given:  
- Tylenol Arthritis 650mg (PRN)  
- Bisacodyl (PRN) |
| #14        | February 2013 | Medication Administration Records did not contain the dosage of the medication which is to be given:  
- Bisacodyl (PRN) |
| #16        | February 2013 | Medication Administration Records did not contain the route of administration for the following medications:  
- Albuterol (PRN)  
- Lozenges (i.e. Sucrets) (PRN)  
- Murine/Visine (PRN) |
- Triple Antibiotic Ointment (PRN)
- Tylenol 325mg (PRN)

As indicated by the Medication Administration Records the individual is to take Mylanta (PRN) or may use "Tums." According to the Physician’s Orders, "Mylanta Sugar Free..." is to be used and does not indicate Tums as a substitute. Medication Administration Record and Physician’s Orders do not match.

March 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Lozenges (i.e. Sucrets) (PRN)
- Murine/Visine (PRN)
- Triple Antibiotic Ointment (PRN)
- Tylenol 325mg (PRN)

As indicated by the Medication Administration Records the individual is to take Mylanta (PRN) or may use “Tums.” According to the Physician’s Orders, “Mylanta Sugar Free...” is to be used and does not indicate Tums as a substitute. Medication Administration Record and Physician’s Orders do not match.

Individual #20
February 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Aspirin 325mg (PRN)
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Citrucel (PRN)</td>
<td></td>
</tr>
<tr>
<td>• Mylanta (PRN)</td>
<td></td>
</tr>
</tbody>
</table>

March 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
• Aspirin 325mg (PRN)
• Citrucel (PRN)
• Mylanta (PRN)
Tag # 1A15.2 and 5I09
Healthcare Documentation

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 20 individual</td>
</tr>
<tr>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>- Health Care Plans</td>
</tr>
<tr>
<td>- Scoliosis</td>
</tr>
<tr>
<td>Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan.</td>
</tr>
<tr>
<td>- Medical Emergency Response Plans</td>
</tr>
<tr>
<td>- Allergy: Codeine</td>
</tr>
<tr>
<td>Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan.</td>
</tr>
<tr>
<td>- GERD</td>
</tr>
<tr>
<td>Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan.</td>
</tr>
</tbody>
</table>

Provider:
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

Provider:

---

QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013

Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134

Page 39 of 54
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. (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. (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). (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 subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken);
assessments of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(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. 
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. 
(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.
(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.
(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):
(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 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.

(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.

(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.

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

(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.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

(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.

(h) Crisis prevention and intervention plans as
well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(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.

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

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.
### Tag # 1A33

**Board of Pharmacy – Med. Storage**

<table>
<thead>
<tr>
<th>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Medication Storage:</strong></td>
</tr>
<tr>
<td>1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.</td>
</tr>
<tr>
<td>2. Drugs to be taken by mouth will be separate from all other dosage forms.</td>
</tr>
<tr>
<td>3. A locked compartment will be available in the refrigerator for those items labeled “Keep in Refrigerator.” The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.</td>
</tr>
<tr>
<td>4. Separate compartments are required for each resident’s medication.</td>
</tr>
<tr>
<td>5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.</td>
</tr>
<tr>
<td>6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.</td>
</tr>
</tbody>
</table>

**Tag # 1A33**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on observation, the Agency did not to ensure proper storage of medication for 1 of 19 individuals.</td>
</tr>
<tr>
<td>Observation included:</td>
</tr>
<tr>
<td>Individual #3</td>
</tr>
<tr>
<td>• Mesilla Valley Hospice “Comfort Med Box,” was not kept in a locked compartment in the refrigerator, as per regulation. Per Hospice the box contained the following medication:</td>
</tr>
<tr>
<td>‣ Tylenol Suppository</td>
</tr>
<tr>
<td>‣ Haldol 2mg/15ml</td>
</tr>
<tr>
<td>‣ Atneprine 1% Opthal Secretion</td>
</tr>
<tr>
<td>‣ Lorazepam 1mg</td>
</tr>
<tr>
<td>‣ Prochlerperperizine 10mg</td>
</tr>
<tr>
<td>‣ Prochlerperperizine Suppository 25mg</td>
</tr>
<tr>
<td>Note: “Comfort Med Box” was pre-sealed by Mesilla Valley Hospice. At the time of the visit the seal was still intact.</td>
</tr>
</tbody>
</table>

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here: →

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
<table>
<thead>
<tr>
<th>a. date</th>
<th>b. time administered</th>
<th>c. name of patient</th>
<th>d. dose</th>
<th>e. practitioner's name</th>
<th>f. signature of person administering or assisting with the administration the dose</th>
<th>g. balance of controlled substance remaining</th>
</tr>
</thead>
</table>

QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013

Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134
<table>
<thead>
<tr>
<th>Tag # 6L13</th>
<th>Community Living Healthcare Reqts.</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 9 of 19 individuals receiving Community Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</strong></td>
<td><strong>G. Health Care Requirements for Community Living Services.</strong></td>
<td></td>
</tr>
<tr>
<td>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual’s health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual’s HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
| Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.  
| 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.  
| (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.  
| (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.  
| (5) That the physical property and grounds are free of hazards to the individual's health and safety.  
| (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:  
| (a) The individual has a primary licensed physician;  
| (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;  
| (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;  
| (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and  
| (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).  

|  
| follow-up found.  

- **Pap Smear Exam**  
  - Individual #9 - As indicated by collateral documentation reviewed, the exam was ordered during the annual physical exam on 12/19/2012. No evidence of exam results were found. *Note: Doctor’s note stated, “Pap??” Doctor then checked yes on exams required.*  
- Individual #16 - As indicated by collateral documentation reviewed, exam was to be completed. No evidence of exam found.

- **Prostate Specific Antigen (PSA)**  
  - Individual #1 - As indicated by collateral documentation reviewed, the exam was ordered during the annual physical exam on 12/19/2012. No evidence of exam results were found or evidence of exam being scheduled.

- **Bone Density Exam**  
  - Individual #1 - As indicated by collateral documentation reviewed, the exam was ordered during the annual physical exam on 12/19/2012. No evidence of exam results were found or evidence of exam being scheduled.

- **Lab Work**  
  - Individual #2 - As indicated by collateral documentation reviewed, lab work for a Lipid Panel was ordered during the annual physical exam on 12/19/2012. No evidence of lab work being completed was found.
  - Individual #19 - As indicated by collateral documentation reviewed, lab work for Lipids, CBC, CMP, CEA, TSH was ordered.

| Pap Smear Exam  
- Individual #9 - As indicated by collateral documentation reviewed, the exam was ordered during the annual physical exam on 12/19/2012. No evidence of exam results were found. *Note: Doctor’s note stated, “Pap??” Doctor then checked yes on exams required.*  
- Individual #16 - As indicated by collateral documentation reviewed, exam was to be completed. No evidence of exam found.

- Prostate Specific Antigen (PSA)  
- Individual #1 - As indicated by collateral documentation reviewed, the exam was ordered during the annual physical exam on 12/19/2012. No evidence of exam results were found or evidence of exam being scheduled.

- Bone Density Exam  
- Individual #1 - As indicated by collateral documentation reviewed, the exam was ordered during the annual physical exam on 12/19/2012. No evidence of exam results were found or evidence of exam being scheduled.

- Lab Work  
- Individual #2 - As indicated by collateral documentation reviewed, lab work for a Lipid Panel was ordered during the annual physical exam on 12/19/2012. No evidence of lab work being completed was found.
- Individual #19 - As indicated by collateral documentation reviewed, lab work for Lipids, CBC, CMP, CEA, TSH was ordered.

QMB Report of Findings – Tresco, Inc. – Southwest Region – April 29 – May 2, 2013
Survey Report #: Q.13.4.DDW.D1135.3.001.FCD.01.134

Page 48 of 54
**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.

---

<table>
<thead>
<tr>
<th>Test Results</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Levels</td>
<td>Individually #1 - As indicated by collateral documentation reviewed, lab work for Ammonia Levels were ordered on 3/14/2013. No evidence of lab results were found.</td>
</tr>
<tr>
<td>T-dap Vaccination</td>
<td>Individually #1 - As indicated by collateral documentation reviewed, the vaccination was ordered during the annual physical on 3/16/2013. No evidence of vaccination being completed.</td>
</tr>
<tr>
<td>Pneumonia Vaccination</td>
<td>Individually #1 - As indicated by collateral documentation reviewed, the vaccination was ordered during the annual physical on 3/16/2013. No evidence of vaccination being completed.</td>
</tr>
<tr>
<td>Hepatitis Vaccination</td>
<td>Individually #1 - As indicated by collateral documentation reviewed, the vaccination was ordered during the annual physical on 3/16/2013. No evidence of vaccination being completed.</td>
</tr>
<tr>
<td>Reflux treatment and Upper Gastrointestinal series with Barium tablet to Visualize Lower Esophagus</td>
<td>Individually #19 - As indicated by collateral documentation reviewed, exam was completed on 3/29/2013. No evidence of exam results were found.</td>
</tr>
</tbody>
</table>
### Tag # 6L25
#### Residential Health and Safety (SL/FL)

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on observation, the Agency did not ensure that each individuals’ residence met all requirements within the standard for 1 of 12 Supported Living residences.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</td>
<td></td>
</tr>
<tr>
<td><strong>Supported Living Requirements:</strong></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 19)</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The following Individuals share a residence:
- #5, 19.

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|---------------------------|

**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**

**L. Residence Requirements for Family Living Services and Supported Living Services**

1. Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:
   a. Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;
   b. General-purpose first aid kit;
   c. When applicable due to an individual’s health status, a blood borne pathogens kit;
   d. Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;
   e. Accessible telephone numbers of poison control centers located within the line of sight of the telephone;
   f. Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;
   g. Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and
   h. Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 19)
evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
Date: June 18, 2013

To: Pam Lillibridge, Chief Executive Officer
Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, New Mexico 88004

E-mail Address: plillibridge@trescomail.org
Region: Southwest
Survey Date: April 29 – May 2, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Focused

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Lillibridge,

Your request for a Reconsideration of Findings was received on May 28, 2013. 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 # 1A08
Determination: The IRF committee is upholding 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 document request form, the document needed was requested and signed by Maureen Gant on 4/30/2013 and not received prior to the end of the survey. The documentation request form clearly states, reason item was not accepted, “evaluation report completed 2/28/13, memo from DTS states plan not complete.” Documentation submitted for this IRF was same documentation seen during on-site survey. On 5/3/2013 the documentation request was finalized and signed by Maureen Gant, indicating acknowledgement of administrative file findings.

Regarding Tag # 1A09
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 documentation supplied, deficiencies noted in tag 1A09 regarding Individual #7 will be removed; the remainder of the deficiencies disputed by you are being upheld due to the following: #3 no Medication Administration Record was provided in IRF documents; #5 Medication Administration Record contains instructions for Dyazide (triamterene-hydrochlorothiazid) PRN only. Orders are specific to routine medication and PRN medication. PRN orders state “prn swelling, or systolic bp 140” while routine medication orders clearly state, “1 PO QD”; #10 although as you indicate the information is listed on “tube feeding plan” it is not contained in the MAR. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A22
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 document received as
evidence the response from DSP #89 regarding the Speech Therapy Plan for Individuals #4 and 12 will be removed from the finding. The remaining citations noted in tag 1A22 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
Date: August 7, 2013

To: Pam Lillibridge, Chief Executive Officer
Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, New Mexico 88004

E-mail Address: plillibridge@trescomail.org

Region: Southwest
Survey Date: April 29 – May 2, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Focused

Dear Ms. Lillibridge;

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

**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 of 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 for the health, safety and personal growth of the people you serve.

Sincerely,

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

CLB/en