Date: February 5, 2020

To: Chris Boston, Executive Director
Provider: Tresco, Inc.
Address: 1800 Copper Loop Building 1
City, State, Zip: Las Cruces, New Mexico 88001

E-mail Address: cboston@trescoinc.org

Region: Southwest
Routine Survey: July 26 - August 1, 2019
Verification Survey: January 3 – 7, 2020

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2018*****:** Supported Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services

Survey Type: Verification

Team Leader: Beverly Estrada, ADN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Member: Monica de Herrera-Pardo, LSW, MSCJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Verna Newman-Sikes AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Chris Boston;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on January 3 – 7, 2020*.

Determination of Compliance:

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

Compliance: This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level:

- Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation) ***(New / Repeat Finding)***
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements ***(New / Repeat Finding)***
- Tag # IS04 Community Life Engagement ***(Repeat Finding)***
- Tag # LS25 Residential Health and Safety (Supported Living & Family Living) ***(New / Repeat Finding)***

Plan of Correction:
The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency's verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance;
2. A Plan of Correction Detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report;
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   5301 Central Ave. NE Suite 400, New Mexico 87108
   MonicaE.Valdez@state.nm.us

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

Please call the Plan of Correction Coordinator Monica Valdez at 505-273-1930 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,

Beverly Estrada, ADN

Beverly Estrada, ADN
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 3, 2020
Contact:	**Tresco, Inc.** Chris Boston, Executive Director **DOH/DHI/QMB** Beverly Estrada, AND, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	January 6, 2020
Present:	**Tresco, Inc.** Analisa Martinez, Community Supports Services Director **DOH/DHI/QMB** Beverly Estrada, ADN, Team Lead/Healthcare Surveyor Monica deHerrera-Pardo, LBSW, MCJ, Healthcare Surveyor Verna Newman-Sikes AA, Healthcare Surveyor
Exit Conference Date:	January 7, 2020
Present:	**Tresco, Inc.** Chris Boston, Chief Executive Operator Sylvia Washington, Chief Operating Officer Analisa Martinez, Director of Community Support Services **DOH/DHI/QMB** Beverly Estrada, ADN, Team Lead/Healthcare Surveyor Monica deHerrera-Pardo, LBSW, MCJ, Healthcare Surveyor Verna Newman-Sikes AA, Healthcare Surveyor **DDSD - Southwest Regional Office** Angie Brooks, Regional Director
Administrative Locations Visited	1
Total Sample Size	15 3 - *Jackson* Class Members 12 - Non-*Jackson* Class Members 10 - Supported Living 4 - Customized In-Home Supports 13 - Customized Community Supports 8 - Community Integrated Employment Services
Persons Served Records Reviewed	15
Direct Support Personnel Interviewed during Routine Survey	16
Direct Support Personnel Records Reviewed	118
Service Coordinator Records Reviewed	1
Nurse Interviews completed during Routine survey	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- 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 / General Events Reports
- 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
NM Attorney General's Office

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 other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); 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 Assurance 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 during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. 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.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:

Service Domain: Service Plan: ISP Implementation - *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):

- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare Documentation - Nurse Availability
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. 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*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. 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.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. 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. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level tag.

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Total Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**17 or more** Total Tags with **75 to 100%** of the Individuals in the sample cited in any CoP Level tag.	**Any Amount** of Standard Level Tags and **6 or more** Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** Standard Level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**up to 16** Standard Level Tags with **75 to 100%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **50 to 74%** of the individuals in the sample cited any tag.			
"Compliance"	**Up to 16** Standard Level Tags with **0 to 74%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **0 to 49%** of the individuals in the sample cited in any tag.					

Agency: **Tresco, Inc. – Southwest**
Program: Developmental Disabilities Waiver
Service: ***2018***: Supported Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services
Survey Type: Verification
Routine Survey: **July 26 - August 1, 2019**
Verification Survey: **January 3 – 7, 2020**

Standard of Care	Routine Survey Deficiencies July 26 - August 1, 2019	Verification Survey New and Repeat Deficiencies January 3 – 7, 2020
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.*		
Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	**Standard Level Deficiency**	**Standard Level Deficiency**
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. 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	Based on residential 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 outcome and action plan for 4 of 10 individuals. As indicated by Individual's ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #5 • According to the Live Outcome; Action Step for "... works on her decorative item" is to be completed 2 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/15 – 21, 2019. *(Date of home visit: 7/29/2019)* Individual #7 • None found regarding: Live Outcome; Action Step: "... will be clean and organize her room using verbal and staff modeling a task" for 7/1 –	**New / Repeat Finding:** Based on the Agency's Plan of Correction approved on 10/10/2019, "Shift Supervisors (at the Las Cruces locations) and the Supervisor (at the Socorro location) will conduct sample audits weekly." No evidence of weekly audits by the Shift Supervisors was provided for November and December 2019 during the Verification survey completed January 3 – 7, 2020.

and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:	19, 2019. Action step is to be completed 2 times per week. *(Date of home visit: 7/29/2019)* Individual #9 • None found regarding: Live Outcome; Action Step: "... will participate in choosing the food that is prepared in the home" for 7/1 – 19, 2019. Action step is to be completed 1 time per week. *(Date of home visit: 7/29/2019)* Individual #12 • According to the Live Outcome; Action Step for "... will use visual schedule to prompt him to complete the watering routine" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 7/1 – 19, 2019. *(Date of home visit: 7/30/2019)*	

16. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 17. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 18. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 19. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 20. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 21. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 22. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.		

Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	Standard Level Deficiency
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.	Based on record review, the Agency did not complete written status reports as required for 14 of 15 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/24/2018 – 4/23/2019; Semi-Annual Report 10/23/2018 - 12/4/2018; Date Completed: 1/7/2019; ISP meeting held on 12/4/2018).* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/10/2018 – 5/9/2019; Semi-Annual Report 11/10/2018 - 1/3/2019; Date Completed: 7/29/2019; ISP meeting held on 1/3/2019).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/14/2017 – 10/13/2019; Semi-Annual Report 4/2018 - 6/2018; Date Completed: 7/20/2019; ISP meeting held on 6/29/2018).* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/1/2018 – 6/30/2019; Semi-Annual Report 1/2019 - 2/2019; Date Completed: 8/1/2019; ISP meeting held on 3/8/2019)* • Individual #13 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/7/2018– 4/6/2019; Semi-Annual Report 10/2018 – 4/2019; Date Completed: 4/29/2019; ISP meeting held on 12/4/2018)* • Individual #14 - None found for 3/2018 - 8/2018 & 9/2018 -11/2018. *(Term of ISP 3/1/2018 - 2/28/2019. ISP meeting held on 12/4/2018)*	**New / Repeat Finding:** Based on record review, the Agency did not complete written status reports as required for 2 of 15 individuals receiving Living Care Arrangements and Community Inclusion. **Supported Living Semi-Annual Reports:** • Individual #5 - None found for 5/2019 - 11/2019. *(Term of ISP 5/10/2019- 5/9/2020).* • Individual #12 - None found for 7/2019 - 12/2019. *(Term of ISP 7/1/2019 - 6/30/2020).* **Customized Community Supports Semi-Annual Reports:** • Individual #5 - None found for 5/2019 - 11/2019. *(Term of ISP 5/10/2019- 5/9/2020).* • Individual #12 - None found for 7/2019 - 12/2019. *(Term of ISP 7/1/2019 - 6/30/2020).*

2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 19: Provider Reporting Requirements:** **19.5 Semi-Annual Reporting:** The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities. Semi-annual reports are required as follows:	**Customized In-Home Supports Semi-Annual Reports:** • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 11/12/2017 – 11/11/2018; Semi-Annual Report 5/12/2018 - 7/19/2018; Date Completed: 7/19/2018; ISP meeting held on 7/19/2018)* **Customized Community Supports Semi-Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/24/2018 – 4/23/2019; Semi-Annual Report 10/23/2018 - 12/4/2018; Date Completed: 1/7/2019; ISP meeting held on 12/4/2018)* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/10/2018 – 5/9/2019; Semi-Annual Report 11/10/2018 - 1/3/2019; Date Completed: 7/29/2019; ISP meeting held on 1/3/2019)* • Individual #7 - None found for 6/2018 - 8/2018. *(Term of ISP 12/13/2017 - 12/12/2018. ISP meeting held on 9/4/2018).* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/14/2017 – 10/13/2018; Semi-Annual Report 4/2018 - 6/2018; Date Completed: 7/20/2019; ISP meeting held on 6/29/2018)* • Individual #10 - None found for 10/2018 - 3/2019 and 4/2019 - 6/2019. *(Term of ISP 10/1/2018 - 9/30/2019. ISP meeting held on 6/19/2018).* • Individual #11 - None found for 5/2018 - 10/2018. *(Term of ISP 5/1/2018 - 4/30/2019).*	

1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports. 2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management for an adult age 21 or older. 3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days). 4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting. 5. Semi-annual reports must contain at a minimum written documentation of: a. the name of the person and date on each page; b. the timeframe that the report covers; c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering; d. a description of progress towards Desired Outcomes in the ISP related to the service provided; e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing); f. significant changes in routine or staffing if applicable; g. unusual or significant life events, including significant change of health or behavioral health condition; h. the signature of the agency staff responsible for preparing the report; and i. any other required elements by service type that are detailed in these standards.	• Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/1/2018– 6/30/2019; Semi-Annual Report 1/1/2019 - 6/30/2019; Date Completed: 8/1/2019; ISP meeting held on 3/8/2019)* • Individual #13 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/7/2018 – 4/6/2019; Semi-Annual Report 10/8/2018 - 12/3/2018; Date Completed: 12/3/2018; ISP meeting held on 12/4/2018)* • Individual #14 - None found for 3/2018 - 8/2018 and 9/2018 - 11/2018. *(Term of ISP 3/1/2018 - 2/29/2019. ISP meeting held on 12/4/2018)* • Individual #15 - None found for 5/2018 - 10/2018 & 11/2018 - 2/2019. *(Term of ISP 5/1/2018 - 4/30/2019. ISP meeting held on 2/20/2019)* **Community Integrated Employment Services Semi-Annual Reports:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/24/2018 – 4/23/2019; Semi-Annual Report 10/2018 - 11/2018; Date Completed: 1/7/2019; ISP meeting held on 12/4/2018)* • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting *(Term of ISP 11/12/2017 – 11/11/2018; Semi-Annual Report 5/2018 – 7/2018; Date Completed: 7/19/2018; ISP meeting held on 7/19/2018)* • Individual #8 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 9/11/2017 – 9/10/2018; Semi-Annual Report 3/11/2018 - 6/6/2018; Date Completed: 7/29/2019; ISP meeting held on 6/6/2018)*	

	• Individual #12 - None found for 7/2018 - 12/2018. *(Term of ISP 7/1/2018 - 6/30/2019).* • Individual #15 - None found for 5/2018 - 10/2018 and 11/2018 - 2/2019. *(Term of ISP 5/1/2018 - 4/30/2019. ISP meeting held on 2/20/2019)* **Nursing Semi-Annual:** • Individual #1 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/24/2018 – 4/23/2019; Semi-Annual Report 10/2018 - 11/2018; Date Completed: 1/7/2019; ISP meeting held on 12/4/2018).* • Individual #2 - None found for 10/2018 - 11/2018. *(Term of ISP 4/1/2018 - 3/31/2019. ISP meeting held on 12/3/2018).* • Individual #3 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 2/28/2018 – 2/27/2019; Semi-Annual Report 8/29/2018 – 10/11/2018; Date Completed: 10/11/2018; ISP meeting held on 10/12/2018)* • Individual #5 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/10/2018 – 5/9/2019; Semi-Annual Report 11/11/2018 - 1/2/2019; Date Completed: 1/2/2019; ISP meeting held on 1/3/2019).* • Individual #6 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 11/12/2018 – 11/11/2019; Semi-Annual Report 5/13/2018 - 11/13/2018; Date Completed: 7/1/2019; ISP meeting held on 7/19/2018)* • Individual #9 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/14/2018 – 10/13/2019; Semi-Annual Report*	

	5/1/2019 - 7/1/2019; Date Completed: 7/1/2019; ISP meeting held on 6/29/2018) • Individual #10 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 10/1/2017 – 9/30/2018; Semi-Annual Report 5/17/2018 - 6/30/2018; Date Completed: 6/18/2019; ISP meeting held on 6/19/2018)* • Individual #11 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 5/1/2018 – 4/30/2019; Semi-Annual Report 11/1/2018 - 1/9/2019; Date Completed: 1/9/2019; ISP meeting held on 1/10/2019)* • Individual #12 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 7/1/2018 – 6/30/2019; Semi-Annual Report 12/31/2018 - 3/4/2019; Date Completed: 3/18/2019; ISP meeting held on 3/8/2019)* • Individual #13 - Report not completed 14 days prior to the Annual ISP meeting. *(Term of ISP 4/7/2018 – 4/6/2019; Semi-Annual Report 10/8/2018 - 12/3/2018; Date Completed: 12/3/2018; ISP meeting held on 12/4/2018)* • Individual #14 - None found for 9/2018 - 11/2018. *(Term of ISP 3/1/2019 - 2/29/2020. ISP meeting held on 12/4/2018).*	

Tag # IS04 Community Life Engagement	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 11: Community Inclusion** **11.1 General Scope and Intent of Services:** Community Inclusion (CI) is the umbrella term used to describe services in this chapter. In general, CI refers to opportunities for people with I/DD to access and participate in activities and functions of community life. The DD waiver program offers Customized Community Supports (CCS), which refers to non-work activities and Community Integrated Employment (CIE) which refers to paid work experiences or activities to obtain paid work. CCS and CIE services are mandated to be provided in the community to the fullest extent possible. **11.3 Implementation of a Meaningful Day:** The objective of implementing a Meaningful Day is to plan and provide supports to implement the person's definition of his/her own meaningful day, contained in the ISP. Implementation activities of the person's meaningful day are documented in daily schedules and progress notes. 1. Meaningful Day includes: a. purposeful and meaningful work; b. substantial and sustained opportunity for optimal health; c. self-empowerment; d. personalized relationships; e. skill development and/or maintenance; and f. social, educational, and community inclusion activities that are directly linked to the vision, Desired Outcomes and Action Plans stated in the person's ISP. 2. Community Life Engagement (CLE) is also sometimes used to refer to "Meaningful Day" or "Adult Habilitation" activities. CLE refers to supporting people in their communities, in non-work activities. Examples of CLE activities may include	Based on record review, the Agency did not have evidence of their implementation of a meaningful day in daily schedules / individual calendar and progress notes for 11 of 13 Individuals. Review of the individual case files found there is no individualized schedule that can be modified easily based on the individual needs, preferences and circumstances and that outline planned activities per day, week and month including date, time, location and cost of the activity: **Calendar / Daily Calendar**: • Not found (#1, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14)	**Repeat Finding:** Based on record review, the Agency did not have evidence of their implementation of a meaningful day in daily schedules / individual calendar and progress notes for 11 of 13 Individuals. Review of the individual case files found there is no individualized schedule that can be modified easily based on the individual needs, preferences and circumstances and that outline planned activities per day, week and month including date, time, location and cost of the activity: **Calendar / Daily Calendar**: • Not found (#1, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14)

participating in clubs, classes, or recreational activities in the community; learning new skills to become more independent; volunteering; or retirement activities. Meaningful Day activities should be developed with the four guideposts of CLE in mind1. The four guideposts of CLE are: a. individualized supports for each person; b. promotion of community membership and contribution; c. use of human and social capital to decrease dependence on paid supports; and d. provision of supports that are outcome-oriented and regularly monitored. 3. The term "day" does not mean activities between 9:00 a.m. to 5:00 p.m. on weekdays. 4. Community Inclusion is not limited to specific hours or days of the week. These services may not be used to supplant the responsibility of the Living Supports Provider Agency for a person who receives both services.		

Standard of Care	Routine Survey Deficiencies July 26 - August 1, 2019	Verification Survey New and Repeat Deficiencies January 3 – 7, 2020
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 # LS25 Residential Health and Safety (Supported Living & Family Living)	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 10: Living Care Arrangements (LCA)** **10.3.6 Requirements for Each Residence:** Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence: 1. has basic utilities, i.e., gas, power, water, and telephone; 2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher; 3. has a general-purpose first aid kit; 4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift; 5. has water temperature that does not exceed a safe temperature (1100 F); 6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP; 7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy; 8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding; 9. supports environmental modifications and assistive technology devices, including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 1 of 8 Living Care Arrangement residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Battery operated or electric smoke detectors or a sprinkler system (#14) • Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#14) *Note: The following Individuals share a residence:* • #7, 9 • #1, 15	**New / Repeat Finding:** Based on the Agency's Plan of Correction approved on 10/10/2019, "Monthly home inspections are required and will be performed by the Shift Supervisor and submitted to the Service Coordinator." No evidence of monthly home inspections by the Shift Supervisor was provided for November and December 2019 during the Verification Survey completed January 3 – 7, 2020.

needs of the individual in consultation with the IDT; 10. has or arranges for necessary equipment for bathing and transfers to support health and safety with consultation from therapists as needed; 11. has the phone number for poison control within line of site of the telephone; 12. has general household appliances, and kitchen and dining utensils; 13. has proper food storage and cleaning supplies; 14. has adequate food for three meals a day and individual preferences; and 15. has at least two bathrooms for residences with more than two residents.		

Standard of Care	Routine Survey Deficiencies	Verification Survey New and Repeat Deficiencies January 3 – 7, 2020
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.*		
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**COMPLETE**
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.*		
Tag # 1A20 Direct Support Personnel Training	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A43.1 General Events Reporting - Individual Reporting	**Standard Level Deficiency**	**COMPLETE**
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 # 1A03 Continuous Quality Improvement System & KPIs	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09 Medication Delivery Routine Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.0 Medication Delivery Routine Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.2 Medication Delivery - Nurse Approval for PRN Medication	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A31 Client Rights/Human Rights	**Condition of Participation Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement - *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # IH32 Customized In-Home Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**

Standard of Care	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Tag # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # IS04 Community Life Engagement	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # LS25 Residential Health and Safety (Supported Living & Family Living)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date:	March 19, 2020
To:	Chris Boston, Executive Director
Provider:	Tresco, Inc.
Address:	1800 Copper Loop Building 1
City, State, Zip:	Las Cruces, New Mexico 88001
E-mail Address:	cboston@trescoinc.org
Region:	Southwest
Routine Survey:	July 26 - August 1, 2019
Verification Survey:	January 3 – 7, 2020
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018*:** Supported Living, Customized In-Home Supports, Customized Community Supports, Community Integrated Employment Services
Survey Type:	Verification

Dear Mr. Boston:

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

Sincerely,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.3.DDW.D1135.3.VER.09.20.079