Date:	June 8, 2021
To:	Edward Santiago, Director of Operations
Provider: Address: State/Zip:	Progressive Residential Services of New Mexico, Inc. 1000 S Main St. Ste A Las Cruces, New Mexico 88005
E-mail Address:	esantiago@prs-nm.org
CC:	Minerva Maese, Program Liaison mmaese@prs-nm.org Eleanor Sanchez, Finance Director esanchez@prs-nm.org Michelle Chavez, RN mchavez@prs-nm.org
Region: Survey Date:	Southwest April 26 – May 10, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized In-Home Supports and Customized Community Supports
Survey Type:	Routine
Team Leader:	Caitlin Wall, BA, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Santiago;

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

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

Non-Compliance: This determination is based on noncompliance with 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 or any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25.1 Caregiver Criminal History Screening
- Tag # 1A26.1 Consolidated On-line Registry Employee Abuse Registry
- Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A09.1 Medication Delivery PRN Medication Administration
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)
- Tag # 1A31 Client Rights / Human Rights

The following tags are identified as Standard Level:

- Tag # 1A08 Administrative Case File (Other Required Documents)
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)
- Tag #1A25 Caregiver Criminal History Screening
- Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry
- Tag # 1A37 Individual Specific Training
- Tag # 1A43.1 General Events Reporting: Individual Reporting
- Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)
- Tag # IS30 Customized Community Supports Reimbursement

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's on-site 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.

You were provided information during the exit meeting portion of your on-site survey. Please refer to this information (Attachment A) for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action for Current Citation:

- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done on an ongoing basis? (i.e. file reviews, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position within your agency)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORA, etc.)
- How is this integrated in your agency's QIS, QI Committee reviews and annual report?

Submission of your Plan of Correction:

Please submit your agency's Plan of Correction in the available space on the two right-hand 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: Monica Valdez, Plan of Correction Coordinator in any of the following ways:**
   a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 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.

Billing Deficiencies:
If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a "Void/Adjust" claim or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Void/Adjust claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

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:

ATTN: QMB Bureau Chief
Request for Informal Reconsideration of Findings
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request/QMB

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 contact the Plan of Correction Coordinator, Monica Valdez at 505-273-1930 or email at: MonicaE.Valdez@state.nm.us 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,

Caitlin Wall, BA, BSW

Caitlin Wall, BA, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	April 26, 2021
Contact:	**Progressive Residential Services of New Mexico, Inc.** Minerva Maese, Program Liaison **DOH/DHI/QMB** Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor
Entrance Conference Date:	April 26, 2021
Present:	**Progressive Residential Services of New Mexico, Inc.** Edward Santiago, Director of Operations Minerva Maese, Program Liaison Eleanor Sanchez, Finance Director Michelle Chavez, RN State Medical Administrator Martha Rubio, RN **DOH/DHI/QMB** Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor Verna Newman-Sikes, AA, Healthcare Surveyor
Exit Conference Date:	May 7, 2021
Present:	**Progressive Residential Services of New Mexico, Inc.** Edward Santiago, Director of Operations Minerva Maese, Program Liaison Eleanor Sanchez, Finance Director Michelle Chavez, RN State Medical Administrator Martha Rubio, RN Vivian Dominguez, Office Manager **DOH/DHI/QMB** Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Verna Newman-Sikes, AA, Healthcare Surveyor **DDSD - SW Regional Office** Jaimie Lopez, DDSD Generalist
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID- 19 Public Health Emergency.)*
Total Sample Size:	6 1 - *Jackson* Class Members 5 - Non-*Jackson* Class Members 6 - Supported Living 6 - Customized Community Supports
Total Homes Observed by Video	5 *(Note: No home visits conducted due to COVID- 19 Public Health Emergency, however, Video Observations were conducted)*
❖ Supported Living Observed by Video	5

	Note: The following Individuals share a SL residence: ➢ #1, 5
Persons Served Records Reviewed	6
Persons Served Interviewed	5 *(Note: Interviews conducted by video / phone due to COVID-19 Public Health Emergency)*
Persons Served Observed	1
Direct Support Personnel Records Reviewed	69
Direct Support Personnel Interviewed	11 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
Service Coordinator Records Reviewed	2
Nurse Interview	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- 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
- 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 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 deficiencies and non-compliance.

Agencies must submit their Plan of Correction within ten (10) business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days may be referred to the DDSD Regional Office for purposes of contract management or 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 will be referred to the IRC for possible actions or sanctions.

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-273-1930 or email at MonicaE.Valdez@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD 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 cited to prevent recurrence and information that ensures the regulation cited comes into and remains in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance (QA) Plan.

If a deficiency has already been corrected since the on-site survey, 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 following details should be considered when developing your Plan of Correction:

The Plan of Correction must address each deficiency cited in the Report of Findings unless otherwise noted with a "No Plan of Correction Required statement." The Plan of Correction must address the five (5) areas listed below:

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 those individuals in similar situations.
3. What Quality Assurance measures will be put into place and what systemic changes made to ensure the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make certain solutions are sustained. The agency must develop a QA plan for ensuring correction is achieved and sustained. This QA plan must be implemented, and the corrective action is evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Individual Served, agency personnel and administrative and service delivery site 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 to service sites, as they are being used, and after they are completed;
- Your processes for ensuring that all required agency personnel are trained on required DDSD required trainings;
- How accuracy in billing/reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management providers, how Individual Service Plans are reviewed to verify they meet requirements, how the timeliness of level of care (LOC) packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to quality data indicators; 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 must 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 POC Coordinator, Monica Valdez at 505-273-1930 or email at MonicaE.Valdez@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Monica Valdez, POC Coordinator in any of the following ways:
    a. Electronically at MonicaE.Valdez@state.nm.us ***(preferred method)***
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Ave NE Suite 400, Albuquerque, New Mexico 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 "approved" 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.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
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. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If documents containing HIPAA Protected Health Information (PHI) documents must be submitted through S-Comm (Therap), Fax or Postal System, do not send PHI directly to NMDOH email accounts. If the documents do not contain protected Health information (PHI) then you may submit your documents 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. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the completion 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 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 Coordination - Nurse Availability / Knowledge
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

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 Bureau Chief **within 10 business days** of receipt of the final Report of Findings **(*Note: No extensions are granted for the IRF)*.**
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: https://nmhealth.org/about/dhi/cbp/irf/
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 IRF process, email the IRF Chairperson, Valerie V. Valdez at valerie.valdez@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.

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: **Progressive Residential Services of New Mexico, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Customized In-Home Supports and Customized Community Supports
Survey Type: Routine
Survey Date: **April 26 – May 10, 2021**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**		
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. 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	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 6 individuals. Review of the Agency administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Positive Behavioral Support Plan:** • Not Current (#4) **Behavior Crisis Intervention Plan:** • Not Found (#2)	**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?)*: →	

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. ***20.5.1 Individual Data Form (IDF):*** The Individual Data Form provides an overview of demographic information as well as other key personal, programmatic, insurance, and health related information. It lists medical information; assistive technology or adaptive equipment; diagnoses; allergies; information about whether a guardian or advance directives are in place; information about behavioral and health related needs; contacts of Provider Agencies and team members and other critical information. The IDF automatically loads information into other fields and forms and must be complete and kept current. This form is initiated by the CM. It must be opened and continuously updated by Living Supports,			

CCS- Group, ANS, CIHS and case management when applicable to the person in order for accurate data to auto populate other documents like the Health Passport and Physician Consultation Form. Although the Primary Provider Agency is ultimately responsible for keeping this form current, each provider collaborates and communicates critical information to update this form. **Chapter 3: Safeguards 3.1.2 *Team Justification Process***: DD Waiver participants may receive evaluations or reviews conducted by a variety of professionals or clinicians. These evaluations or reviews typically include recommendations or suggestions for the person/guardian or the team to consider. The team justification process includes: 1. Discussion and decisions about non-health related recommendations are documented on the Team Justification form. 2. The Team Justification form documents that the person/guardian or team has considered the recommendations and has decided: a. to implement the recommendation; b. to create an action plan and revise the ISP, if necessary; or c. not to implement the recommendation currently. 3. All DD Waiver Provider Agencies participate in information gathering, IDT meeting attendance, and accessing supplemental resources if needed and desired. 4. The CM ensures that the Team Justification Process is followed and complete.			

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	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 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.	Based on administrative 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 2 of 6 individuals. As indicated by Individuals 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 #1 • According to the Live Outcome; Action Step for "… will label and pack meal" 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 3/2021. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • According to the Fun/Relationships Outcome; Action Step for "Make greeting card" is to be completed 2 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2021. Individual #2 • According to the Fun/Relationships Outcome; Action Step for "… will research an activity" is to be completed 1 time per week. Evidence found indicated it was not	**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?)*: →	

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:	being completed at the required frequency as indicated in the ISP for 2/2021 - 3/2021.		

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. 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.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13: Nursing Services *13.2.11 Training and Implementation of Plans:*** 1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs. 2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training. **Chapter 17: Training Requirement** **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 4 of 11 Direct Support Personnel. **When DSP were asked, if the Individual had a Positive Behavioral Supports Plan (PBSP), have you been trained on the PBSP and what does the plan cover, the following was reported:** • DSP #521 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #1) • DSP #558 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #1) **When DSP were asked, if they received training on the Individual's Behavioral Crisis Intervention Plan (BCIP) and if so, what the plan covered, the following was reported:** • DSP #550 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has a Behavioral Crisis Intervention Plan. (Individual #5)	**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?)*: →	

described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible.	• DSP #526 stated, "No. He doesn't have one." According to the Individual Specific Training Section of the ISP, the individual has a Behavioral Crisis Intervention Plan. (Individual #5) **When DSP were asked, if the individual required a physical restraint such as MANDT, CPI or Handle with care, the following was reported:** • DSP #550 stated, "No. Not at all." According to the Behavioral Crisis Intervention Plan for ISP Term 5/28/2020 – 5/27/2021, "If his behavior continues to endanger the health and well-being of him or other consumers, physical holds may be used." (Individual #5) • DSP #526 stated, "No." According to the Behavioral Crisis Intervention Plan for ISP Term 5/28/2020 – 5/27/2021, "If his behavior continues to endanger the health and well-being of him or other consumers, physical holds may be used." (Individual #5)		

5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.			

Tag #1A25 Caregiver Criminal History Screening	Standard Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.	Based on record review, the Agency did not maintain documentation indicating Caregiver Criminal History Screening was completed as required for 2 of 71 Agency Personnel. **The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:** **Direct Support Personnel (DSP):** • #506 – Date of hire 8/18/2006. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** • #539 – Date of hire 9/3/2020. *The Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings due to the Public Health Emergency. Effective April 1, 2020, Special COVID – 19 Supplement #1: Fingerprinting Guidance: Employees hired during this time and who could not complete a fingerprint appointment are required to submit their fingerprint cards within 30 days of the termination of the declaration of the PHE.* ***(Note: No POC required for #539. Please ensure that fingerprint cards are submitted within 30 days of the termination of the declaration of the PHE)***	**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?)*: →	

C. Conditional Employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes.			

NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Tag # 1A25.1 Caregiver Criminal History Screening	Condition of Participation Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **A. General:** The responsibility for compliance with the requirements of the act applies to both the care provider and to all applicants, caregivers and hospital caregivers. All applicants for employment to whom an offer of employment is made or caregivers and hospital caregivers employed by or contracted to a care provider must consent to a nationwide and statewide criminal history screening, as described in Subsections D, E and F of this section, upon offer of employment or at the time of entering into a contractual relationship with the care provider. Care providers shall submit all fees and pertinent application information for all applicants, caregivers or hospital caregivers as described in Subsections D, E and F of this section. Pursuant to Section 29-17-5 NMSA 1978 (Amended) of the act, a care provider's failure to comply is grounds for the state agency having enforcement authority with respect to the care provider] to impose appropriate administrative sanctions and penalties. **B. Exception:** A caregiver or hospital caregiver applying for employment or contracting services with a care provider within twelve (12) months of the caregiver's or hospital caregiver's most recent nationwide criminal history screening which list no disqualifying convictions shall only apply for a statewide criminal history screening upon offer of employment or at the time of entering into a contractual relationship with the care provider. At the discretion of the care provider a nationwide criminal history screening, additional to the required statewide criminal history screening, may be requested.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation indicating Caregiver Criminal History Screening was completed as required for 7 of 71 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #502 – Date of hire 11/7/2018. • #503 – Date of hire 11/22/2019. • #513 – Date of hire 3/14/2001. • #520 – Date of hire 1/31/2008. • #521 – Date of hire 8/2/2017. • #535 – Date of hire 1/16/2019. • #525 – Date of hire 12/13/2018.	**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?)*: →	

C. Conditional Employment: Applicants, caregivers, and hospital caregivers who have submitted all completed documents and paid all applicable fees for a nationwide and statewide criminal history screening may be deemed to have conditional supervised employment pending receipt of written notice given by the department as to whether the applicant, caregiver or hospital caregiver has a disqualifying conviction. **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **G. Maintenance of Records:** Care providers shall maintain documentation relating to all employees and contractors evidencing compliance with the act and these rules. (1) During the term of employment, care providers shall maintain evidence of each applicant, caregiver or hospital caregiver's clearance, pending reconsideration, or disqualification. (2) Care providers shall maintain documented evidence showing the basis for any determination by the care provider that an employee or contractor performs job functions that do not fall within the scope of the requirement for nationwide or statewide criminal history screening. A memorandum in an employee's file stating "This employee does not provide direct care or have routine unsupervised physical or financial access to care recipients served by [name of care provider]," together with the employee's job description, shall suffice for record keeping purposes.			

NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 22 of 71 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #501 – Date of hire 8/10/2020, completed 8/11/2020. • #502 – Date of hire 11/7/2018, completed 4/30/2021. • #512 – Date of hire 3/20/2020, completed 3/30/2020. • #523 – Date of hire 5/1/2020, completed 5/4/2020. • #524 – Date of hire 1/22/2021, completed 1/23/2021. • #525 – Date of hire 12/13/2018, completed 1/2/2019. • #526 – Date of hire 5/14/2020, completed 5/15/2020. • #528 – Date of hire 1/26/2021, completed 2/10/2021. • #531 – Date of hire 1/26/2021, completed 2/11/2021.	**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?)*: →	

appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.	• #532 – Date of hire 11/24/2020, completed 11/25/2020. • #533 – Date of hire 10/14/2020, completed 10/15/2020. • #537 – Date of hire 10/29/2020, completed 10/30/2020. • #539 – Date of hire 9/3/2020, completed 9/11/2020. • #540 – Date of hire 8/12/2019, completed 9/21/2020. • #542 – Date of hire 1/17/2019, completed 3/20/2019. • #546 – Date of hire 12/28/2020, completed 1/6/2021. • #549 – Date of hire 3/18/2020, completed 4/14/2020. • #551 – Date of hire 12/17/2018, completed 11/25/2020. • #554 – Date of hire 11/18/2020, completed 11/25/2020. • #555 – Date of hire 9/4/2013, completed 9/25/2020. • #563 – Date of hire 7/21/2020, completed 7/24/2020. • #567 – Date of hire 8/14/2008, completed 2/9/2021.		

Tag # 1A26.1 Consolidated On-line Registry Employee Abuse Registry	Condition of Participation Level Deficiency		
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry, including the name, address, date of birth, social security number, and other	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 71 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Personnel (DSP):** • #521 – Date of hire 8/2/2017. • #565 – Date of hire 2/15/2021.	**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?)*: →	

appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A37 Individual Specific Training	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 17: Training Requirements:** The purpose of this chapter is to outline requirements for completing, reporting and documenting DDSD training requirements for DD Waiver Provider Agencies as well as requirements for certified trainers or mentors of DDSD Core curriculum training. **17.1 Training Requirements for Direct Support Personnel and Direct Support Supervisors:** Direct Support Personnel (DSP) and Direct Support Supervisors (DSS) include staff and contractors from agencies providing the following services: Supported Living, Family Living, CIHS, IMLS, CCS, CIE and Crisis Supports. 1. DSP/DSS must successfully: a. Complete IST requirements in accordance with the specifications described in the ISP of each person supported and as outlined in 17.10 Individual-Specific Training below. b. Complete training on DOH-approved ANE reporting procedures in accordance with NMAC 7.1.14 c. Complete training in universal precautions. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements d. Complete and maintain certification in First Aid and CPR. The training materials shall meet OSHA requirements/guidelines. e. Complete relevant training in accordance with OSHA requirements (if job involves exposure to hazardous chemicals). f. Become certified in a DDSD-approved system of crisis prevention and intervention (e.g., MANDT, Handle with Care, CPI) before using EPR. Agency DSP and DSS shall maintain certification in a DDSD-approved system if any person they	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 3 of 71 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (#507, 529, 540)	**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?)*: →	

support has a BCIP that includes the use of EPR. g. Complete and maintain certification in a DDSD-approved medication course if required to assist with medication delivery. h. Complete training regarding the HIPAA. 2. Any staff being used in an emergency to fill in or cover a shift must have at a minimum the DDSD required core trainings and be on shift with a DSP who has completed the relevant IST. **17.10 Individual-Specific Training:** The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill. Reaching an **awareness level** may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness. Reaching a **knowledge level** may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by the author or their designee. Verbal or written recall or demonstration may verify this level of competence. Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the			

techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported. 1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends. 2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher. 3. The competency level of the training is based on the IST section of the ISP. 4. The person should be present for and involved in IST whenever possible. 5. Provider Agencies are responsible for tracking of IST requirements. 6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings. 7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still			

responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan. **17.10.1 IST Training Rosters:** IST Training Rosters are required for all IST trainings: 1. IST Training Rosters must include: a. the name of the person receiving DD Waiver services; b. the date of the training; c. IST topic for the training; d. the signature of each trainee; e. the role of each trainee (e.g., CIHS staff, CIE staff, family, etc.); and f. the signature and title or role of the trainer. 2. A competency-based training roster (required for CARMPs) includes all information above but also includes the level of training (awareness, knowledge, or skilled) the trainee has attained. (See Chapter 5.5 Aspiration Risk Management for more details about CARMPs.) 3. A copy of the training roster is submitted to the agency employing the staff trained within seven calendar days of the training date. The original is retained by the trainer.			

Tag # 1A43.1 General Events Reporting: Individual Reporting	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 19: Provider Reporting Requirements: 19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In-Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 5 of 6 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:** **Individual #2** • General Events Report (GER) indicates on 10/1/2020 the Individual tripped on ramp and fell on pavement outside of van. (Fall). GER was approved 10/12/2020. **Individual #4** • General Events Report (GER) indicates on 3/28/2021 the Individual was uncomfortable in his chair. Staff related to Nurse the foley seemed to be in place but was not sure. Instructed staff to transport to urgent care/ER. (Hospital). GER was pending approval. **Individual #5** • General Events Report (GER) indicates on 7/7/2020 the Individual was in the room yelling. He began to get really agitated. (PRN Psychotropic Use). GER was approved 7/14/2020. • General Events Report (GER) indicates on 10/6/2020 the staff entered the home for their shift and smelt gas. Called the fire department. (Emergency Services Used). GER was approved 10/9/2020.	**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?)*: →	

reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **<u>The following events need to be reported in the Therap GER:</u>** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat **<u>Entry Guidance:</u>** Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information,	• General Events Report (GER) indicates on 11/5/2020 the Individual became angry and agitated, yelling at the staff before running into his room. Individual scratched forehead and punched a hole in the wall. (PRN Psychotropic Use). GER was approved 11/17/2020. • General Events Report (GER) indicates on 1/13/2021 the Individual received COVID-19 shot. (COVID-19 vaccine). GER was approved 1/18/2021. • General Events Report (GER) indicates on 2/10/2021 the Individual needed COVID-19 shot. (COVID-19 vaccine). GER was approved 2/18/2021. **Individual #6** • General Events Report (GER) indicates on 8/31/2020 the Individual was walking in home towards sofa when individual got closer to couch and fell on right knee. (Fall without Injury). GER was approved 10/12/2020. • General Events Report (GER) indicates on 11/8/2020 the Individual lost balance leaning to right side. (Fall without Injury). GER was approved 11/19/2020. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #1** • Documentation reviewed indicates on 3/25/2021 the Individual was given medication on the wrong day. (Medication Error). No GER was found. *(Note: Entered in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.	**Individual #2** • Documentation reviewed indicates on 3/24/2021 the Individual was given a PRN for Antacid 200 mg Calcium 500 mg (given 1 time) not documented on the MAR. (Medication Documentation Error). No GER was found. **Individual #4** • Documentation reviewed indicates on 3/5/2021 the Individual was not given the 12:00 PM dosage of Gabapentin 300 mg capsule. (Medication Error). No GER was found. • Documentation reviewed indicates on 3/10 - 12, and 20, 21, 2021 the Individual was not given the 8:00 AM dosage of Boost Liquid. (Medication Error). No GER was found. **Individual #5** • Documentation reviewed indicates on 3/14/2021 the Individual was not given the 8:00 am dosage of Vitamin D2 50,000 units capsule. (Medication Error). No GER was found. *(Note: Entered in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Individual #6** • Documentation reviewed indicates on 3/31/2021 the Individual was not given the 8:00 pm dosage of Denta 5000 Plus 1.1% Cream. (Medication Error). No GER was found. *(Note: Entered in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*		

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 1. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist; b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 1 of 6 individuals receiving Living Care Arrangements and Community Inclusion. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Living Care Arrangements / Community Inclusion (Individuals Receiving Multiple Services):*** **Family Medicine:** • Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 2/15/2021. Physician consultation form was not linked / attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Gastroenterology:** • Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 3/16/2021. Physician consultation form was not linked / attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)*	**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?)*: →	

as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting. **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. 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. **20.5.3 *Health Passport and Physician Consultation Form:*** All Primary and Secondary Provider Agencies must use the *Health Passport* and *Physician Consultation* form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The *Health Passport* also includes a standardized form to use at medical appointments called the *Physician Consultation* form. The *Physician Consultation* form contains a list of all current medications. **Chapter 10: Living Care Arrangements (LCA) Living Supports-Supported Living: 10.3.9.6.1 Monitoring and Supervision** 4. Ensure and document the following: a. The person has a Primary Care Practitioner. b. The person receives an annual physical examination and other examinations as recommended by a Primary Care Practitioner or specialist. c. The person receives annual dental check-ups and other check-ups as recommended by a licensed dentist. d. The person receives a hearing test as recommended by a licensed audiologist. e. The person receives eye examinations as			

recommended by a licensed optometrist or ophthalmologist. 5. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). **10.3.10.1 Living Care Arrangements (LCA) Living Supports-IMLS: 10.3.10.2 General Requirements:** 9 . Medical services must be ensured (i.e., ensure each person has a licensed Primary Care Practitioner and receives an annual physical examination, specialty medical care as needed, and annual dental checkup by a licensed dentist). **Chapter 13 Nursing Services: 13.2.3 General Requirements:** 1. Each person has a licensed primary care practitioner and receives an annual physical examination and specialty medical/dental care as needed. Nurses communicate with these providers to share current health information.			

Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 22:Quality Improvement Strategy (QIS):** A QIS at the provider level is directly linked to the organization's service delivery approach or underlying provision of services. To achieve a higher level of performance and improve quality, an organization is required to have an efficient and effective QIS. The QIS is required to follow four key principles: 1. quality improvement work in systems and processes; 2. focus on participants; 3. focus on being part of the team; and 4. focus on use of the data. As part of a QIS, Provider Agencies are required to evaluate their performance based on the four key principles outlined above. Provider Agencies are required to identify areas of improvement, issues that impact quality of services, and areas of non-compliance with the DD Waiver Service Standards or any other program requirements. The findings should help inform the agency's QI plan. ***22.2 QI Plan and Key Performance Indicators (KPI):*** Findings from a discovery process should result in a QI plan. The QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving goals, and identifying opportunities for improvement. The QI plan describes the processes that the Provider Agency uses in each phase of the QIS: discovery, remediation, and sustained improvement. It describes the frequency of data collection, the source and types of data gathered, as well as the methods used to	Based on record review and interview, the Agency did not maintain or implement a Quality Improvement System (QIS), as required by standards. Review of information found: • Review of the findings identified during the on-site survey (April 26 – May 10, 2021) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.	**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?)*: →	

analyze data and measure performance. The QI plan must describe how the data collected will be used to improve the delivery of services and must describe the methods used to evaluate whether implementation of improvements is working. The QI plan shall address, at minimum, three key performance indicators (KPI). The KPI are determined by DOH-DDSQI) on an annual basis or as determined necessary. ***22.3 Implementing a QI Committee:*** A QI committee must convene on at least a quarterly basis and more frequently if needed. The QI Committee convenes to review data; to identify any deficiencies, trends, patterns, or concerns; to remedy deficiencies; and to identify opportunities for QI. QI Committee meetings must be documented and include a review of at least the following: 1. Activities or processes related to discovery, i.e., monitoring and recording the findings; 2. The entities or individuals responsible for conducting the discovery/monitoring process; 3. The types of information used to measure performance; 4. The frequency with which performance is measured; and 5. The activities implemented to improve performance. ***22.4 Preparation of an Annual Report:*** The Provider Agency must complete an annual report based on the quality assurance (QA) activities and the QI Plan that the agency has implemented during the year. The annual report shall: 1. Be submitted to the DDSD PEU by February 15th of each calendar year. 2. Be kept on file at the agency, and made available to DOH, including DHI upon request.			

3. Address the Provider Agency's QA or compliance with at least the following: a. compliance with DDSD Training Requirements; b. compliance with reporting requirements, including reporting of ANE; c. timely submission of documentation for budget development and approval; d. presence and completeness of required documentation; e. compliance with CCHS, EAR, and Licensing requirements as applicable; and f. a summary of all corrective plans implemented over the last 24 months, demonstrating closure with any deficiencies or findings as well as ongoing compliance and sustainability. Corrective plans include but are not limited to: i. IQR findings; ii. CPA Plans related to ANE reporting; iii. POCs related to QMB compliance surveys; and iv. PIPs related to Regional Office Contract Management. 4. Address the Provider Agency QI with at least the following: a. data analysis related to the DDSD required KPI; and b. the five elements required to be discussed by the QI committee each quarter. **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: F. Quality assurance/quality improvement program for community-based service providers:** The community-based service			

provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A09 Medication Delivery Routine Medication Administration	Condition of Participation Level Deficiency		
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 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the month of March 2021. Based on record review, 5 of 6 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 March 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Lamotrogine 25 mg (2 times daily) – Blank 3/31 (8:00 AM) • Vitamin D2 50,000 Unit (1 time every other week) Every other Sunday – Blank 3/14 (8:00 AM) Medication Administration Records contained missing entries for Humalog 100 unit/ml Insulin Pen and noted "FYI", however did not provide further instruction of where to document. Surveyor located a Blood Glucose Log which indicated Insulin was administered, however MAR did not indicate this on the following days: • Humalog 100 unit/ml Insulin Pen (3 times daily per sliding scale) – Blank 3/1, 4, 5, 6, 15, 18, 23, 24 (administered twice), 25, 27 (administered twice), 28, 29, 30. Physician's Orders indicated the following medications were to be given. The following	**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?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	Medications were not documented on the Medication Administration Records: • Fluticasone Propionate 50mcg (2 times daily) Individual #3 March 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Loratadine 10 mg (1 time daily) – Blank 3/14, 15 (8:00 AM) • Acyclovir 400 mg (2 times daily) – Blank 3/13 (8:00 AM) • Azelastine HCL 137 mcg (1 time daily) – Blank 3/14, 15 (8:00 AM) Individual #4 March 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Gabapentin 300 mg (3 times daily) – Blank 3/5 (12:00 PM) • Boost Liquid (1 time daily) – Blank 3/10, 11, 12, 20, 21 (8:00 AM) Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Simvastatin 40 mg tablet (1 time daily) Individual #5 March 2021 Medication Administration Records contained missing entries. No		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR). **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: (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	documentation found indicating reason for missing entries: • Vitamin D2, 50,000 unit (1 time weekly) Every other Sunday – Blank 3/14 (8:00 AM) Individual #6 March 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Divalproex Sodium ER 500 mg ER 24 Hr (3 times daily) – Blank 3/13 (8:00 PM) • Tamsulosin HCL 0.4 mg (1 time daily) – Blank 3/31 (8:00 PM) • Denta 5000 plus 1.1% cream (1 time daily) – Blank 3/31 (8:00 PM)		

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.			

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency		
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 20.6 Medication Administration Record (MAR):** A current Medication Administration Record (MAR) must be maintained in all settings where medications or treatments are delivered. Family Living Providers may opt not to use MARs if they are the sole provider who supports the person with medications or treatments. However, if there are services provided by unrelated DSP, ANS for Medication Oversight must be budgeted, and a MAR must be created and used by the DSP. Primary and Secondary Provider Agencies are responsible for: 1. Creating and maintaining either an electronic or paper MAR in their service setting. Provider Agencies may use the MAR in Therap, but are not mandated to do so. 2. Continually communicating any changes about medications and treatments between Provider Agencies to assure health and safety. 7. Including the following on the MAR: a. The name of the person, a transcription of the physician's or licensed health care provider's orders including the brand and generic names for all ordered routine and PRN medications or treatments, and the diagnoses for which the medications or treatments are prescribed; b. The prescribed dosage, frequency and method or route of administration; times and dates of administration for all ordered routine or PRN prescriptions or treatments; over the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of March 2021. Based on record review, 3 of 6 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 March 2021 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Antacid 200 mg Calcium (500 mg) – PRN – 3/27 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Antacid 200 mg Calcium (500 mg) – PRN – 3/27 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Humalog 100 unit/ml Insulin Pen (3 times daily per sliding scale) – 3/1, 4, 5, 6, 15, 18, 23, 24 (administered twice), 25, 27 (administered twice), 28, 29, 30 Individual #4 March 2021 No Effectiveness was noted on the Medication Administration Record for the following PRN medication:	**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?)*: →	

counter (OTC) or "comfort" medications or treatments and all self-selected herbal or vitamin therapy; c. Documentation of all time limited or discontinued medications or treatments; d. The initials of the individual administering or assisting with the medication delivery and a signature page or electronic record that designates the full name corresponding to the initials; e. Documentation of refused, missed, or held medications or treatments; f. Documentation of any allergic reaction that occurred due to medication or treatments; and g. For PRN medications or treatments: i. instructions for the use of the PRN medication or treatment which must include observable signs/symptoms or circumstances in which the medication or treatment is to be used and the number of doses that may be used in a 24-hour period; ii. clear documentation that the DSP contacted the agency nurse prior to assisting with the medication or treatment, unless the DSP is a Family Living Provider related by affinity of consanguinity; and iii. documentation of the effectiveness of the PRN medication or treatment. **Chapter 10 Living Care Arrangements** ***10.3.4 Medication Assessment and Delivery:*** Living Supports Provider Agencies must support and comply with: 1. the processes identified in the DDSD AWMD training;	• Banophen 25 mg – PRN – 3/2 (given 1 time) • Acetaminophen 325 mg – PRN –3/25 (given 1 time) Individual #5 March 2021 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Clonazepam 1 mg – PRN – 3/2 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Clonazepam 1 mg – PRN – 3/2 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Clonazepam 1 mg – PRN – 3/2 (given 1 time) No dosage was noted on the back of the Medication Administration Record for the following PRN medication for the following dates: • Clonazepam – PRN – 3/2 (given 1 time)		

2. the nursing and DSP functions identified in the Chapter 13.3 Part 2- Adult Nursing Services; 3. all Board of Pharmacy regulations as noted in Chapter 16.5 Board of Pharmacy; and 4. documentation requirements in a Medication Administration Record (MAR) as described in Chapter 20.6 Medication Administration Record (MAR).			

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 13 Nursing Services: *13.2.12 Medication Delivery:*** Nurses are required to: 1. Be aware of the New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. 2. Communicate with the Primary Care Practitioner and relevant specialists regarding medications and any concerns with medications or side effects. 3. Educate the person, guardian, family, and IDT regarding the use and implications of medications as needed. 4. Administer medications when required, such as intravenous medications; other specific injections; via NG tube; non-premixed nebulizer treatments or new prescriptions that have an ordered assessment. 5. Monitor the MAR or treatment records at least monthly for accuracy, PRN use and errors. 6. Respond to calls requesting delivery of PRNs from AWMD trained DSP and non-related (surrogate or host) Family Living Provider Agencies. 7. Assure that orders for PRN medications or treatments have: a. clear instructions for use; b. observable signs/symptoms or circumstances in which the medication is to be used or withheld; and c. documentation of the response to and effectiveness of the PRN medication administered. 8. Monitor the person's response to the use of routine or PRN pain medication and contact the prescriber as needed regarding its effectiveness. 9. Assure clear documentation when PRN	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation of PRN authorization as required by standard for 4 of 6 Individuals. Individual #2 March 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 325 mg – PRN – 3/23 (given 1 time) • Antacid 200 mg Calcium (500 mg) – PRN – 3/27 (given 1 time) Individual #3 March 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Acetaminophen 325 mg – PRN – 3/8 (given 2 times) • Ibuprofen 800 mg – PRN – 3/5 (given 2 times) Individual #4 March 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN	**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?)*: →	

medications are used, to include: a. DSP contact with nurse prior to assisting with medication. i. The only exception to prior consultation with the agency nurse is to administer selected emergency medications as listed on the Publications section of the DOH-DDSD -Clinical Services Website https://nmhealth.org/about/ddsd/pgsv/clinical/. b. Nursing instructions for use of the medication. c. Nursing follow-up on the results of the PRN use. d. When the nurse administers the PRN medication, the reasons why the medications were given and the person's response to the medication.	medication was found for the following PRN medication: • Zinc Oxide 20% – PRN – 3/29 (given 1 time) • Acetaminophen 325 mg – PRN – 3/3 (given 2 times) *(Note: MAR indicated medication was given twice by two different staff. Second page of the MAR only indicated Nurse approval for entry made by one staff.)* • Banophen 25 mg – PRN – 3/4 (given 1 time) • Mometasone Furoate 0.1% – PRN – 3/5 (given 1 time) • Polyethylene Glycol 3350 17 gm – PRN – 3/4 (given 1 time) Individual #5 March 2021 No documentation of the verbal authorization from the Agency nurse prior to each administration/assistance of PRN medication was found for the following PRN medication: • Clonazepam 1 mg – PRN – 3/2 (given 1 time)		

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency		
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. 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 4 of 6 Individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Healthcare Passport:** ➢ Did not contain Name of Physician (#3, 6) *(Note: Health Passport corrected during on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Did not contain Emergency contact information (#5, 6) *(Note: Health Passport corrected during on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Did not contain Guardianship/Healthcare Decision Maker (#5) *(Note: Health Passport corrected during on-site survey. Provider please complete POC for ongoing QA/QI.)* **Health Care Plans:** ***Body Mass Index*** • Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Falls***	**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?)*: →	

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 3 Safeguards: 3.1.1 *Decision Consultation Process (DCP):*** Health decisions are the sole domain of waiver participants, their guardians or healthcare decision makers. Participants and their healthcare decision makers can confidently make decisions that are compatible with their personal and cultural values. Provider Agencies are required to support the informed decision making of waiver participants by supporting access to medical consultation, information, and other available resources according to the following: 2. The DCP is used when a person or his/her guardian/healthcare decision maker has concerns, needs more information about health-related issues, or has decided not to follow all or part of an order, recommendation, or suggestion. This includes, but is not limited to: a. medical orders or recommendations from the Primary Care Practitioner, Specialists or other licensed medical or healthcare practitioners such as a Nurse Practitioner (NP or CNP), Physician Assistant (PA) or Dentist;	• Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. ***Falls/Injuries/Fractures*** • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. Not Linked or Attached in Therap. ***Hypertension*** • Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Oral Hygiene/Dental Care*** • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. Not Linked or Attached in Therap. ***Toileting/Bowel Function/Constipation*** • Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. Not Linked or Attached in Therap. **Medical Emergency Response Plans:** ***Falls*** • Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. ***Oral Hygiene Protocol*** • Individual #5 - As indicated by the IST section of ISP the individual is required to		

b. clinical recommendations made by registered/licensed clinicians who are either members of the IDT or clinicians who have performed an evaluation such as a video-fluoroscopy; c. health related recommendations or suggestions from oversight activities such as the Individual Quality Review (IQR) or other DOH review or oversight activities; and d. recommendations made through a Healthcare Plan (HCP), including a Comprehensive Aspiration Risk Management Plan (CARMP), or another plan. 2. When the person/guardian disagrees with a recommendation or does not agree with the implementation of that recommendation, Provider Agencies follow the DCP and attend the meeting coordinated by the CM. During this meeting: a. Providers inform the person/guardian of the rationale for that recommendation, so that the benefit is made clear. This will be done in layman's terms and will include basic sharing of information designed to assist the person/guardian with understanding the risks and benefits of the recommendation. b. The information will be focused on the specific area of concern by the person/guardian. Alternatives should be presented, when available, if the guardian is interested in considering other options for implementation. c. Providers support the person/guardian to make an informed decision. d. The decision made by the person/guardian during the meeting is accepted; plans are modified; and the IDT honors this health decision in every setting.	have a plan. Not Linked or Attached in Therap.		

Chapter 13 Nursing Services: ***13.2.5 Electronic Nursing Assessment and Planning Process:*** The nursing assessment process includes several DDSD mandated tools: the electronic Comprehensive Nursing Assessment Tool (e-CHAT), the Aspiration Risk Screening Tool (ARST) and the Medication Administration Assessment Tool (MAAT) . This process includes developing and training Health Care Plans and Medical Emergency Response Plans. The following hierarchy is based on budgeted services and is used to identify which Provider Agency nurse has primary responsibility for completion of the nursing assessment process and related subsequent planning and training. Additional communication and collaboration for planning specific to CCS or CIE services may be needed. The hierarchy for Nursing Assessment and Planning responsibilities is: 1. Living Supports: Supported Living, IMLS or Family Living via ANS; 2. Customized Community Supports- Group; and 3. Adult Nursing Services (ANS): a. for persons in Community Inclusion with health-related needs; or b. if no residential services are budgeted but assessment is desired and health needs may exist. ***13.2.6 The Electronic Comprehensive Health Assessment Tool (e-CHAT)*** 1. The e-CHAT is a nursing assessment. It may not be delegated by a licensed nurse to a non-licensed person. 2. The nurse must see the person face-to-face to complete the nursing assessment. Additional information may be gathered from members of the IDT and other sources. 3. An e-CHAT is required for persons in FL,			

SL, IMLS, or CCS-Group. All other DD Waiver recipients may obtain an e-CHAT if needed or desired by adding ANS hours for assessment and consultation to their budget. 4. When completing the e-CHAT, the nurse is required to review and update the electronic record and consider the diagnoses, medications, treatments, and overall status of the person. Discussion with others may be needed to obtain critical information. 5. The nurse is required to complete all the e-CHAT assessment questions and add additional pertinent information in all comment sections. ***13.2.7 Aspiration Risk Management Screening Tool (ARST)*** ***13.2.8 Medication Administration Assessment Tool (MAAT):*** 1. A licensed nurse completes the DDSD Medication Administration Assessment Tool (MAAT) at least two weeks before the annual ISP meeting. 2. After completion of the MAAT, the nurse will present recommendations regarding the level of assistance with medication delivery (AWMD) to the IDT. A copy of the MAAT will be sent to all the team members two weeks before the annual ISP meeting and the original MAAT will be retained in the Provider Agency records. 3. Decisions about medication delivery are made by the IDT to promote a person's maximum independence and community integration. The IDT will reach consensus regarding which criteria the person meets, as indicated by the results of the MAAT and the nursing recommendations, and the decision is documented this in the ISP. **13.2.9 Healthcare Plans (HCP)*:***			

1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted. ***13.2.10 Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.			

Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form: All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.			

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency		
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 6 Individuals. No current Human Rights Approval was found for the following: • "Staff will monitor phone usage at the home" - Last Review was dated 12/10/2020. (Individual #3) A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • "Locked cabinets for clothing in room" - No evidence found of Human Rights Committee approval. (Individual #5) • "Not allowed to go into a public restroom alone" - No evidence found of Human Rights Committee approval. (Individual #5)	**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?)*: →	

Chapter 2: Human Rights: Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. **Chapter 3 Safeguards:** ***3.3.1 HRC Procedural Requirements:*** 1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative. 2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review. 3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting. 5. HRC committees are required to meet at least on a quarterly basis. 6. A quorum to conduct an HRC meeting is at			

least three voting members eligible to vote in each situation and at least one must be a community member at large. 7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations. 8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction. ***3.3.3 HRC and Behavioral Support:*** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support			

is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral			

purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. **3.4 Emergency Physical Restraint (EPR):** Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. ***3.4.5 Human Rights Committee:*** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs: 1. participate in training regarding required constitution and oversight activities for HRCs; 2. review any BCIP, that include the use of EPR; 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and 5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
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 # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 21: Billing Requirements: 21.4 Recording Keeping and Documentation Requirements:** DD Waiver Provider Agencies must maintain all records necessary to demonstrate proper provision of services for Medicaid billing. At a minimum, Provider Agencies must adhere to the following: 1. The level and type of service provided must be supported in the ISP and have an approved budget prior to service delivery and billing. 2. Comprehensive documentation of direct service delivery must include, at a minimum: a. the agency name; b. the name of the recipient of the service; c. the location of the service; d. the date of the service; e. the type of service; f. the start and end times of the service; g. the signature and title of each staff member who documents their time; and h. the nature of services. 3. A Provider Agency that receives payment for treatment, services, or goods must retain all medical and business records for a period of at least six years from the last payment date, until ongoing audits are settled, or until involvement of the state Attorney General is completed regarding settlement of any claim, whichever is longer. 4. A Provider Agency that receives payment for treatment, services or goods must retain all medical and business records relating to any	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 2 of 6 individuals. Individual #2 March 2021 • The Agency billed 540 units of Customized Community Supports (Individual) (H2021 HB U1) from 3/1/2021 through 3/31/2021. Documentation received accounted for 528 units. *(Note: Void/Adjust provided on-site during survey. Provider please complete POC for ongoing QA/QI.)* Individual #3 March 2021 • The Agency billed 552 units of Customized Community Supports (Individual) (H2021 HB U1) from 3/1/2021 through 3/31/2021. Documentation received accounted for 504 units. *(Note: Void/Adjust provided on-site during survey. Provider please complete POC for ongoing QA/QI.)*	**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?)*: →	

of the following for a period of at least six years from the payment date: a. treatment or care of any eligible recipient; b. services or goods provided to any eligible recipient; c. amounts paid by MAD on behalf of any eligible recipient; and d. any records required by MAD for the administration of Medicaid. **21.9 Billable Units:** The unit of billing depends on the service type. The unit may be a 15-minute interval, a daily unit, a monthly unit or a dollar amount. The unit of billing is identified in the current DD Waiver Rate Table. Provider Agencies must correctly report service units. **21.9.1 Requirements for Daily Units:** For services billed in daily units, Provider Agencies must adhere to the following: 1. A day is considered 24 hours from midnight to midnight. 2. If 12 or fewer hours of service are provided, then one-half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24-hour period. 3. The maximum allowable billable units cannot exceed 340 calendar days per ISP year or 170 calendar days per six months. 4. When a person transitions from one Provider Agency to another during the ISP year, a standard formula to calculate the units billed by each Provider Agency must be applied as follows: a. The discharging Provider Agency bills the number of calendar days that services were provided multiplied by .93 (93%). b. The receiving Provider Agency bills the remaining days up to 340 for the ISP			

year. **21.9.2 Requirements for Monthly Units:** For services billed in monthly units, a Provider Agency must adhere to the following: 1. A month is considered a period of 30 calendar days. 2. At least one hour of face-to-face billable services shall be provided during a calendar month where any portion of a monthly unit is billed. 3. Monthly units can be prorated by a half unit. 4. Agency transfers not occurring at the beginning of the 30-day interval are required to be coordinated in the middle of the 30-day interval so that the discharging and receiving agency receive a half unit. **21.9.3 Requirements for 15-minute and hourly units**: For services billed in 15-minute or hourly intervals, Provider Agencies must adhere to the following: 1. When time spent providing the service is not exactly 15 minutes or one hour, Provider Agencies are responsible for reporting time correctly following NMAC 8.302.2. 2. Services that last in their entirety less than eight minutes cannot be billed.			

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Cabinet Secretary

Date:	July 26, 2021
To:	Edward Santiago, Director of Operations
Provider:	Progressive Residential Services of New Mexico, Inc.
Address:	1000 S Main St. Ste A
State/Zip:	Las Cruces, New Mexico 88005
E-mail Address:	esantiago@prs-nm.org
CC:	Minerva Maese, Program Liaison mmaese@prs-nm.org
	Eleanor Sanchez, Finance Director esanchez@prs-nm.org
	Michelle Chavez, RN mchavez@prs-nm.org
Region:	Southwest
Survey Date:	April 26 – May 10, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized In-Home Supports and Customized Community Supports
Survey Type:	Routine

Dear Mr. Santiago and Ms. Maese:

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

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

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

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

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

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

Monica Valdez, BS

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

Q.21.4.DDW.D4244.3.RTN.07.21.207