NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	December 20, 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 State Medical Administrator mchavez@prs-nm.org Diane Nelson, COO Dnelson@prs-nm.org
Region: Routine Survey: Verification Survey:	Southwest April 26 – May 10, 2021 November 8 – 19, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized In-Home Supports and Customized Community Supports
Survey Type:	Verification
Team Leader:	Caitlin Wall, BA, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Verna Newman-Sikes, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Sally Rel, MS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Santiago;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on April 26 – May 10, 2021*.

Determination of Compliance:

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) 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 # 1A09 Medication Delivery Routine Medication Administration ***(New / Repeat Findings)***
- Tag # 1A09.1 Medication Delivery PRN Medication Administration ***(New / Repeat Findings)***
- Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication***(New / Repeat Findings)***
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) ***(Repeat Findings)***

The following tags are identified as Standard Level:

- Tag # 1A22 Agency Personnel Competency ***(New / Repeat Findings)***

However, due to the new/repeat deficiencies your agency will be referred to the Internal Review Committee (IRC). Your agency will also be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

Plan of Correction:

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

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

Submission of your Plan of Correction:

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

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

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

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

Please 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 survey or the report. 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:	November 8, 2021
Contact:	**Progressive Residential Services of New Mexico, Inc.** Minerva Maese, Program Liaison **DOH/DHI/QMB** Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor
Exit Conference Date:	November 19, 2021
Present:	**Progressive Residential Services of New Mexico, Inc.** Edward Santiago, Director of Operations Minerva Maese, Program Liaison Michelle Chavez, RN State Medical Administrator Stephen Rodriguez, Service Coordinator **DOH/DHI/QMB** Caitlin Wall, BA, BSW, Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor Verna Newman-Sikes, AA, Healthcare Surveyor Sally Rel, MS, Healthcare Surveyor
Administrative Locations Visited:	0 *(Note: No administrative locations visited due to COVID- 19 Public Health Emergency.)*
Total Sample Size:	5 1 - *Jackson* Class Members 4 - Non-*Jackson* Class Members 5 - Supported Living 5 - Customized Community Supports
Persons Served Records Reviewed	5
Direct Support Personnel Records Reviewed	61
Direct Support Personnel Interviewed during Routine Survey	10 *(Note: Interviews conducted by video / phone due to COVID- 19 Public Health Emergency)*
Service Coordinator Records Reviewed	3
Nurse Interview completed during Routine Survey	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 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 <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *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)

<u>Service Domain: Qualified Providers -</u> *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: Verification
Routine Survey: **April 26 – May 10, 2021**
Verification Survey: **November 8 – 19, 2021**

Standard of Care	Routine Survey Deficiencies April 26 – May 10, 2021	Verification Survey New and Repeat Deficiencies November 8 – 19, 2021
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**	**Standard 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.	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,	**New/Repeat Finding:** Per the Plan of Correction approved on 7/26/2021, "PRS Service Coordinator and Residential Specialist (DSS) or designee (i.e., Program Liaison) during monthly house visit will review and assess the DSP on shift knowledge about individuals IST." No evidence of completed monthly house visits with a review and assessment of DSP knowledge about Individual's IST was provided during the Verification Survey completed November 8 – 19, 2021.

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	the individual has a Behavioral Crisis Intervention Plan. (Individual #5) • 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)	

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.		

Standard of Care	Routine Survey Deficiencies April 26 – May 10, 2021	Verification Survey New and Repeat Deficiencies November 8 – 19, 2021
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**	**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 counter (OTC) or "comfort"	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.	**New/Repeat Findings:** 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 October 2021. Based on record review, 3 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #2 October 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Fish Oil 3-360-1200 MG (1 time daily) – Blank 10/1, 31 (8:00 PM) • Hydrocortisone 1 % (1 time daily) – Blank 10/2 – 31 (8:00 AM) • Vitamin B-12 1,000 MCG (1 time daily) – Blank 10/8 (8:00 AM) • Xarelto 20 mg (1 time daily) – Blank 10/1, 8 (5:00 PM) • Zolpidem Tartrate 5 mg (1 time daily) – Blank 10/1 (8:00 PM) Individual #4 October 2021

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; 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	Physician's Orders indicated the following medications were to be given. The following 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 documentation found indicating reason for missing entries:	Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Famotidine 20 mg (2 times daily) – Blank 10/31 (8:00 PM) • Senna 8.6 mg (2 tablets) (2 times daily) – Blank 10/31 (8:00 PM) • Vitamin D3 125 mcg (5,000 units) (1 time daily) – Blank 10/31 (8:00 pm) • Ketoconazole 2% Cream 1 G (3 times daily) – Blank 10/18, 31 (3:00 PM) Individual #6 October 2021 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Carbidopa – Levodopa 25-250 mg (3 times a day) – Blank 10/2, 3, 8, 10, 12, 24, 28 (2:00 PM) • Divalproex Sodium ER 500 mg SR 24 Hr (3 times daily) – Blank 10/2, 3, 8, 11, 24, 28 (2:00 PM)

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 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.	• 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)	

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Condition of Participation Level Deficiency	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 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	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: • Banophen 25 mg – PRN – 3/2 (given 1 time)	**New/Repeat Findings:** 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 October 2021. Based on record review, 2 of 5 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #2 October 2021 No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Magnesium Citrate 200 mg – PRN – 10/27, 28 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Magnesium Citrate 200 mg – PRN – 10/27, 28 (given 1 time) Individual #4 October 2021 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Acetaminophen 325 mg – PRN – 10/13, 14, 15, 20, 24 (given 1 time) • Banophen 25 mg – PRN – 10/12, 13, 15, 16, 19, 20, 24 (given 1 time) • Geri-tussin 100 mg/5mL – PRN – 10/20 (given 2 times)

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; 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).	• 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)	• Hydrocortisone 1% – PRN – 10/11 (given 1 time) • Phillips Milk of Magnesia 400 mg/5mL – PRN – 10/4, 31 (given 1 time) • Polyethylene Glycol 350 17 gram/dose – PRN – 10/4, 11 (given 1 time) • Remedy Calazime 3.5-0.2-2.69-16.5% – PRN – 10/7 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325 mg – PRN – 10/13, 14, 15, 20, 24 (given 1 time) • Banophen 25 mg – PRN – 10/12, 13, 15, 16, 19, 20, 24 (given 1 time) • Geri-tussin 100 mg/5mL – PRN – 10/20 (given 2 times) • Hydrocortisone 1% – PRN – 10/11 (given 1 time) • Phillips Milk of Magnesia 400 mg/5mL – PRN – 10/4, 31 (given 1 time) • Polyethylene Glycol 350 17 gram/dose – PRN – 10/4, 11 (given 1 time) • Remedy Calazime 3.5-0.2-2.69-16.5% – PRN – 10/7 (given 1 time) No Time of Administration was noted on the Medication Administration Record for the following PRN medication: • Acetaminophen 325 mg – PRN – 10/13, 14, 15, 20, 24 (given 1 time)

		• Banophen 25 mg – PRN – 10/12, 13, 15, 16, 19, 20, 24 (given 1 time) • Geri-tussin 100 mg/5mL – PRN – 10/20 (given 2 times) • Hydrocortisone 1% – PRN – 10/11 (given 1 time) • Phillips Milk of Magnesia 400 mg/5mL – PRN – 10/4, 31 (given 1 time) • Polyethylene Glycol 350 17 gram/dose – PRN – 10/4, 11 (given 1 time) • Remedy Calazime 3.5-0.2-2.69-16.5% – PRN – 10/7 (given 1 time) Medication Administration Records Indicated Acetaminophen 325mg was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/13, 14, 15, 20, 24 Medication Administration Records Indicated Banophen 25mg was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/12, 13, 15, 16, 19, 20, 24 Medication Administration Records Indicated Geri-tussin 100mg/5ml was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/20 Medication Administration Records Indicated Hydrocortisone 1% was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/11

		Medication Administration Records Indicated Phillips Milk of Magnesia 400mg/5ml was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/4, 31 Medication Administration Records Indicated Polyethylene was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/4, 11 Medication Administration Records Indicated Remedy Calazime 3.5-0.2-2.69-16.5% was given. MAR did not indicate the exact dosage each time the med was assisted or administered for the following dates: • 10/7

Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	Condition of Participation Level Deficiency	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 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	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 medication was found for the following PRN medication: • Zinc Oxide 20% – PRN – 3/29 (given 1 time)	**New/Repeat Findings:** 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 2 of 5 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: • Magnesium Citrate 200 mg – PRN – 10/27, 28 (given 1 time) Individual #4 October 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 – 10/13, 14, 15, 20, 24 (given 1 time) • Banophen 25 mg – PRN – (given 1 time) • Geri-tussin 100 mg/5mL – PRN – 10/20 (given 2 times) • Hydrocortisone 1% – PRN – 10/11 (given 1 time) • Phillips Milk of Magnesia 400 mg/5mL – PRN – 10/4, 31 (given 1 time)

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.	• 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)	• Polyethylene Glycol 350 17 gram/dose – PRN – 10/4, 11 (given 1 time) • Remedy Calazime 3.5-0.2-2.69-16.5% – PRN – 10/7 (given 1 time)

Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency	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 maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the	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***	**Repeat Findings:** 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 2 of 5 Individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Health Care 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. ***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. **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.

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: 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 as the Individual Quality Review (IQR) or other DOH review or oversight activities; and	• 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 have a plan. Not Linked or Attached in Therap.	

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 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.		

Standard of Care	Routine Survey Deficiencies April 26 – May 10, 2021	Verification Survey New and Repeat Deficiencies November 8 – 19, 2021
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**	**COMPLETE**
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag #1A25 Caregiver Criminal History Screening	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A25.1 Caregiver Criminal History Screening	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A26.1 Consolidated On-line Registry Employee Abuse Registry	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A43.1 General Events Reporting: Individual Reporting	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A03 Continuous Quality Improvement System & Key Performance Indicators (KPIs)	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A31 Client Rights / Human Rights	**Condition of Participation Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Tag # 1A22 **Agency Personnel Competency**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A09 **Medication Delivery Routine Medication Administration**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Tag # 1A09.1 **Medication Delivery PRN Medication Administration**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # 1A09.2 **Medication Delivery Nurse Approval for 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?)*: →	

Tag # 1A15.2 **Administrative Case File: Healthcare Documentation (Therap and Required Plans)**	**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?)***: →**	

NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

DAVID R. SCRASE, M.D.
Acting Cabinet Secretary

Date:	February 11, 2022
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 State Medical Administrator mchavez@prs-nm.org
	Diane Nelson, COO Dnelson@prs-nm.org
Region:	Southwest
Routine Survey:	April 26 – May 10, 2021
Verification Survey:	November 8 – 19, 2021
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Customized In-Home Supports and Customized Community Supports
Survey Type:	Verification

Dear Mr. Santiago:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Monica Valdez, BS

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