Date:	June 25, 2015
To:	Melissa Alvarez-Ortega, Director
Provider:	Progressive Residential Services of New Mexico, Inc.
Address:	250 South Main Street Suite A
State/Zip:	Las Cruces, New Mexico 88001
E-mail Address:	malvarez@prs-nm.org
Region:	Southwest
Routine Survey:	June 23 - 25, 2014
Verification Survey:	June 3 - 4, 2015
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports) ***2007:*** *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type:	Verification
Team Leader:	Florence G. Mulheron, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Alvarez - Ortega;

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 June 23 – 25, 2014*.

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

Compliance with Conditions of Participation.

However, due to the new/repeat standard level deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up. You are also required to continue your Plan of Correction. 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;
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**
   1170 North Solano Drive Suite D, Las Cruces, New Mexico 88001

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

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

Please call the Plan of Correction Coordinator at 575-373-5716, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Florence G. Mulheron, BA

Florence G. Mulheron, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement/Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	June 3, 2015	
Present:	**Progressive Residential Services of New Mexico, Inc.** Melissa Ortega, Director **DOH/DHI/QMB** Florence G. Mulheron, BA, Team Lead/Healthcare Surveyor	
Exit Conference Date:	June 4, 2015	
Present:	**Progressive Residential Services of New Mexico, Inc.** Melissa Ortega, Director **DOH/DHI/QMB** Florence G. Mulheron, BA, Team Lead/Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	7 2 - *Jackson* Class Members 5 - Non-*Jackson* Class Members 6 - Supported Living 1 - Customized In-Home Supports 2 - Adult Habilitation 5 - Customized Community Supports
Persons Served Records Reviewed	Number:	7
Direct Support Personnel Records Reviewed	Number:	88
Service Coordinator Records Reviewed	Number:	2

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Medical Emergency Response Plans
    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records

- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
DOH – Internal Review Committee

Attachment B

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

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

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

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

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

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

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

Conditions of Participation (CoPs)

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

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for

significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

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

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

Service Domain: Level of Care

Condition of Participation:

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

Service Domain: Plan of Care

Condition of Participation:

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

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Plan of Care

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

The QMB determination of *Compliance with Conditions of Participation* indicates that a provider is in compliance with all Conditions of Participation, (CoP). The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation in all relevant Service Domains. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) out of compliance in any of the Service Domains.

Partial-Compliance with Conditions of Participation

The QMB determination of *Partial-Compliance with Conditions of Participation* indicates that a provider is out of compliance with Conditions of Participation in one (1) to two (2) Service Domains. The agency may have one or more Condition level tags within a Service Domain. This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains.

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

Non-Compliance with Conditions of Participation

The QMB determination of *Non-Compliance with Conditions of Participation* indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Attachment C

Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

Introduction:

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

Instructions:

1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
2. The written request for an IRF *must* be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at Crystal.Lopez-Beck@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.

Agency: **Progressive Residential Services of New Mexico, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Monitoring Type: Verification Survey
Routine Survey: **June 23 – 25, 2014**
Verification Survey: **June 3 – 4, 2015**

Standard of Care	Routine Survey Deficiencies June 23 – 25, 2014	Verification Survey New and Repeat Deficiencies June 3 – 4, 2015
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**Standard Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on	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 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 7 of 8 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:	**New / Repeat Finding:** Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 2 of 7 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #4 • None found regarding: Live Outcome/Action Step: "… will work on his ISP Presentation" for 11/2014 – 5/2015.

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. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Individual #1 • Action Step for Live outcome: "…will display a piece of his artwork once a month at a location of his choice" Was not completed at the required frequency for 3/2014 - 5/2014. Individual #4 • None found for 3/2014 - 5/2014. Individual #5 • None found regarding: Fun Outcome/Action Step: "…will visit with relatives" for 5/2014. Individual #7 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live Outcome. No documentation was found regarding implementation of the current ISP outcomes for 3/2014 – 4/2014. Individual #8 • "…will work on his paintings" is to be completed 1 time per week. Action Step was NOT being completed at the required frequency for 5/2014. • None found regarding: Health Outcome/Action Step: "…will exercise." for 3/2014 - 5/2014. **Customized Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #7 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn Outcome. No documentation was found	**When Surveyor asked about the lack of implementation, the following was reported:** • SC 269 stated, "He has not worked on the goal because he has no tablet." *After further discussions it was reported that no data or documentation could be provided as the outcome was not being implemented due to individual not having assistive technology (tablet). No documented evidence was found to indicate the agency was assisting the individual to acquire needed technology.* Individual #8 May 2015 • According to the Live Outcome; Action Step for "… Will plan a meal and create a shopping list" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP. • According to the Live Outcome; Action Step for "… will shop for needed items" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP. • According to the Health/Other Outcome; Action Step for … will exercise" 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.

	regarding implementation of the current ISP outcomes for 3/2014 – 5/2014. **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found for 6/11 - 21, 2014. Individual #2 • None found for 6/1 - 8, 2014. Individual #4 • None found regarding: Live Outcome/Action Step: "…select task" for 6/1 – 22, 2014. • None found regarding: Live Outcome/Action Step: "…complete task." for 6/1 – 22, 2014 Individual #6 • None found regarding: Live Outcome/Action Step: "…will work on her journal" for 6/1 – 23 Individual #7 • None found for 6/1 - 23, 2014.	

Standard of Care	Routine Survey Deficiencies June 23 – 25, 2014	Verification Survey New and Repeat Deficiencies June 3 – 4, 2015
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 **Criminal Caregiver History Screening**	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **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. **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;	Based on record review, the Agency did not maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 6 of 71 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #211 – Date of hire 6/5/2012. • #231 – Date of hire 5/19/2014. • #244 – Date of hire 5/19/2014. • #253 – Date of hire 2/3/2014. • #260 – Date of hire 2/3/2014. **Service Coordination Personnel (SC):** • #270 – Date of hire 1/4/2013. *(Note: Personnel file for #270 was not able to be reviewed as it was in a locked file and could not be verified).*	**New / Repeat Finding:** 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 no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 7 of 90 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #274 – Date of hire 3/2/2015. • #282 – Date of hire 3/2/2015. • #289 – Date of hire 3/2/2015. • #291 – Date of hire 3/2/2015. • #292 – Date of hire 3/2/2015. • #298 – Date of hire 1/5/2015.

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.		• #299 – Date of hire 3/2/2015.

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency	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. 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	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 1 of 71 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Service Coordination Personnel (SC):** • #270 – Date of hire 1/4/2013. *(Note: Personnel file for #270 was not able to be reviewed as it was in a locked file and could not be verified).*	**New / Repeat Finding:** 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 3 of 90 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Personnel (DSP):** • #279 – Date of hire 4/6/2015. • #303 – Date of hire 4/6/2015. • #306 – Date of hire 4/20/2015.

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.		

Standard of Care	Routine Survey Deficiencies June 23 – 25, 2014	Verification Survey New and Repeat Deficiencies June 3 – 4, 2015
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 CQI System	NA	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans;	**Not applicable during the routine survey.**	**New Finding:** Based on record review, the Agency did not develop and implement a Continuous Quality Management System. Review of the findings from the June 3 - 4, 2015 verification survey indicated the Agency had deficiencies noted, including a Condition of Participation level finding. The agency continues to have substantial deficiencies, which neither were not corrected nor addressed since the last survey.

(4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities		

	services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.		

Tag # 1A27 Incident Mgt. Late and Failure to Report	Standard Level Deficiency	Standard Level Deficiency
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and	Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 8 of 15 individuals. Individual #5 • Incident date 11/22/2013. Allegation was Neglect. Incident report was received on 11/26/2013. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #9 • Incident date 3/31/2014. Allegation was Emergency Services. Incident report was received on 4/3/2014. IMB issued a Late Reporting for Emergency Services. Individual #10 • Incident date 12/20/2013. Allegation was Abuse & Neglect. Incident report was received on 1/17/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #11 • Incident date 9/23/2013. Allegation was Neglect. Incident report was received on 9/27/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #12 • Incident date 6/12/2013. Allegation was Neglect. Incident report was received on 6/19/2013.	**New / Repeat Finding:** Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 10 of 19 individuals. Individual #3 • Incident date 1/12/2015. Allegation was Neglect. Incident report was received on 1/19/2015. IMB issued a Late Reporting for Neglect. Individual #5 • Incident date 6/17/2014. Allegation was Neglect. Incident report was received on 7/14/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." • Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 4/17/2015. IMB issued a Late Reporting for Neglect. Individual #10 • Incident date 4/30/2015. Allegation was Neglect. Incident report was received 5/1/2015. IMB issued a Late Reporting for Neglect. Individual #12 • Incident date 6/3/2014. Allegation was Neglect. Incident report was received on 7/14/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." • Incident date 00-00-0000. Allegation was Abuse and Neglect. Incident report was received on 1/19/2015.

instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.	Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #13 • Incident date 8/16/2013. Allegation was Neglect. Incident report was received on 8/22/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." • Incident date 9/24/2013. Allegation was Neglect. Incident report was received on 9/27/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #14 • Incident date 12/2/2013. Allegation was Abuse. Incident report was received on 12/9/2013. Late Reporting. IMB Late and Failure Report indicated incident of Abuse was "Unconfirmed." • Incident date 12/2/2013. Allegation was Emergency Services. Incident report was received on 12/9/2013. IMB issued a Late Reporting for Emergency Services. Individual #15 • Incident date 10/9/2013. Allegation was Neglect. Incident report was received on 10/22/2013. Failure to Report.. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."	Late Reporting. IMB Late and Failure Report indicated incident of Abuse and Neglect was "Unconfirmed." Individual #13 • Incident date 11/9/2014. Allegation was Neglect. Incident report was received on 11/11/2014. IMB issued a Late Reporting for Neglect. Individual #14 • Incident date 00-00-000. Allegation was Neglect. Incident report was received on 1/20/2015. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." • Incident date 00-00-0000. Allegation was Abuse and Neglect. Incident report was received on 5/15/2015. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed." Individual #16 • Incident date 5/25/2015. Allegation was Neglect. Incident report was received on 6/1/2015. IMB issued a Late Reporting for Neglect. Individual #17 • Incident date 00-00-0000. Allegation was Neglect. Incident report was received on 2/16/2015. IMB issued a Late Reporting for Neglect. Individual #18 • Incident date 10/21/2014. Allegation was Neglect and Environmental Hazard. Incident report was received on 10/27/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect and Environmental Hazard was "Unconfirmed." Individual #19

		• Incident date 9/30/2014. Allegation was Neglect. Incident report was received on 10/6/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." • Incident date 10/20/2014. Allegation was Neglect Environmental Hazard. Incident report was received on 10/27/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect Environmental Hazard was "Unconfirmed."

Standard of Care	Routine Survey Deficiencies June 23 – 25, 2014	Verification Survey New and Repeat Deficiencies June 3 – 4, 2015
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 Agency Case File	**Standard Level Deficiency**	**Completed**
Tag # 1A08.1 Agency Case File - Progress Notes	**Standard Level Deficiency**	**Completed**
Tag # LS14 / 6L14 Residential Case File	**Standard Level Deficiency**	**Completed**
Tag # LS17 / 6L17 Reporting Requirements (Community Living Reports)	**Standard Level Deficiency**	**Completed**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**Completed**
Tag # 1A22 Agency Personnel Competency	**Standard Level Deficiency**	**Completed**
Tag # 1A28.1 Incident Mgt. System - Personnel Training	**Standard Level Deficiency**	**Completed**
Tag # 1A36 Service Coordination Requirements	**Standard Level Deficiency**	**Completed**
Tag # 1A37 Individual Specific Training	**Standard Level Deficiency**	**Completed**
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	**Standard Level Deficiency**	**Completed**
Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	**Standard Level Deficiency**	**Completed**

Tag # 1A31 Client Rights/Human Rights	**Standard Level Deficiency**	**Completed**
Tag # LS13 / 6L13 Community Living Healthcare Reqts.	**Standard Level Deficiency**	**Completed**
Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	**Standard Level Deficiency**	**Completed**
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 # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**	**Completed**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**Completed**
Tag # IH32 Customized In-Home Supports Reimbursement	**Standard Level Deficiency**	**Completed**

Date: August 6, 2015

To: Melissa Alvarez-Ortega, Director
Provider: Progressive Residential Services of New Mexico, Inc.
Address: 250 South Main Street Suite A
State/Zip: Las Cruces, New Mexico 88001

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

Region: Southwest
Routine Survey: June 23 - 25, 2014
Verification Survey: June 3 - 4, 2015
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type: Verification

Dear Ms. Alvarez - Ortega;

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 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,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.15.4.DDW.D4244.3.VER.09.15.218