NEW MEXICO
Department of Health
Division of Health Improvement

MICHELLE LUJAN GRISHAM
Governor

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

Date:	February 7, 2022
To:	Analisa Martinez, Community Support Services Director
Provider:	Tresco, Inc.
Address:	1800 Copper Loop
State/Zip:	Las Cruces, New Mexico 88005
E-mail Address:	amartinez@trescoinc.org
Region:	Southwest
Routine Survey:	May 17 – 28, 2021
Verification Survey:	January 3 – 13, 2022
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living; Customized In-Home Supports; Customized Community Supports, and Community Integrated Employment Services
Survey Type:	Verification
Team Leader:	Lei Lani Nava, MPH, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Analisa Martinez:

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 May 17 – 28, 2021*.

Determination of Compliance

The Division of Health Improvement, Quality Management Bureau has determined your agency is 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 # 1A31 Client Rights / Human Rights ***(Repeat Findings)***

The following tags are identified as Standard Level:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan (Not Completed at Frequency) ***(New / Repeat Findings)***

- Tag # 1A43.1 General Events Reporting: Individual Reporting ***(New / Repeat Findings)***
- Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans) ***(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 call the Plan of Correction Coordinator Monica Valdez at 505-273-1930 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Lei Lani Nava, MPH

Lei Lani Nava, MPH
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 3, 2022
Contact:	**Tresco, Inc.** Analisa Martinez, Community Support Services Director **DOH/DHI/QMB** Lei Lani Nava, MPH, Team Lead/Healthcare Surveyor
Exit Conference Date:	January 13, 2022
Present:	**Tresco, Inc.** Analisa Martinez, Community Support Services Director **DOH/DHI/QMB** Lei Lani Nava, MPH, Team Lead/Healthcare Surveyor Amanda Castaneda-Holguin, MPA, Healthcare Surveyor Supervisor **DDSD - SW Regional Office** Jaime Lopez, Social & Community Service Coordinator
Administrative Locations Visited:	0 (*Note: No administrative locations visited due to COVID-19 Public Health Emergency*)
Total Sample Size:	12 2 - *Jackson* Class Members 10 - Non-*Jackson* Class Members 6 - Supported Living 4 - Customized In-Home Supports 9 - Customized Community Supports 7 - Community Integrated Employment
Persons Served Records Reviewed	12
Direct Support Personnel Records Reviewed	98
Direct Support Personnel Interviewed during Routine Survey	12 *(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
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - °Individual Service Plans
    - °Progress on Identified Outcomes
    - °Healthcare Plans
    - °Medication Administration Records
    - °Medical Emergency Response Plans

    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up
    - Other Required Health Information
- Internal Incident Management Reports and System Process / General Events Reports
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
NM Attorney General's Office

Attachment B

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

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Assurance system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on provider compliance or non-compliance with standards and regulations identified during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

Conditions of Participation (CoPs)

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

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

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

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

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

Service Domain: Qualified Providers - *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

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

- **1A20 -** Direct Support Personnel Training
- **1A22 -** Agency Personnel Competency

- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *The State, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*

Potential Condition of Participation Level Tags, if compliance is below 85%:
- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare 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: **Tresco, Inc. – Southwest Region**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Customized In-Home Supports, Customized Community Supports, and Community Integrated Employment Services
Survey Type: Verification
Routine Survey: **May 17 – 28, 2021**
Verification Survey: **January 3 – 13, 2022**

Standard of Care	Routine Survey Deficiencies May 17 – 28, 2021	Verification Survey New and Repeat Deficiencies January 3 – 13, 2022
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 # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and	Based on administrative record review and interview, 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 3 of 13 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #7 • According to the Live Outcome; Action Step for "…will assist putting clothes away" 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 for 4/2021. • According to the Fun Outcome; Action Step for "…will research places to visit" is to be completed 1 time per week. Evidence found indicated it was	**New / Repeat Finding:** Based on administrative record review and interview, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 12 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Living Data Collection / Data Tracking/Progress with regards to ISP Outcomes**: Individual #5 • According to the Live Outcome; Action Step for "…will choose a kitchen activity using a picture or written list of choirs" 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 for 11/2021.

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]

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019

Chapter 6: Individual Service Plan (ISP)
6.8 ISP Implementation and Monitoring: All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.

Chapter 20: Provider Documentation and Client Records 20.2 Client Records Requirements: All DD Waiver Provider Agencies are required to

not being completed at the required frequency as indicated in the ISP for 4/2021.

Customized In-Home Supports Data Collection / Data Tracking/Progress with regards to ISP Outcomes:

Individual #8

- According to the Health Outcome; Action Step for "…will track her expenses with a budget app" 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 for 3/2021 – 4/2021.

- According to the Health Outcome; Action Step for "…will pick an exercise routine" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2021 – 4/2021.

- According to the Health Outcome; Action Step for "…will complete her exercise routine" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2021 – 4/2021.

Individual #13

- According to the Work Outcome; Action Step for "…will check phone is charged" 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 for 3/2021 – 4/2021.

- According to the Work Outcome; Action Step for "…will learn how to send text messages" is to be completed 1 time per week. Evidence found indicated it was not being completed at the

- According to the Live Outcome; Action Step for "… will choose a day to work on kitchen activity" 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 for 11/2021.

- According to the Live Outcome; Action Step for "… will complete task with a maximum of 3 verbal prompts" 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 for 11/2021.

Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #5

- According to the Work/Learn Outcome; Action Step for "…will choose a family member to contact" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2021 - 11/2021.

- According to the Work/Learn Outcome; Action Step for "…will choose a form of communication" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2021 - 11/2021.

- According to the Work/Learn Outcome; Action Step for "…will send completed communication" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2021 - 11/2021.

create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.	required frequency as indicated in the ISP for 3/2021 – 4/2021. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #7 • According to the Work/Learn Outcome; Action Step for "…will choose location given 2 choices using communication system" 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 for 3/2021 - 4/2021. **Community Integrated Employment Services Data Collection/Data Tracking / Progress with regards to ISP Outcomes:** Individual #8 • According to the Work/Learn, Outcome; Action Step for "…will improve health to ensure less call in's" 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 for 3/2021 – 4/2021.	• According to the Fun Outcome; Action Step for "…will choose activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2021. • According to the Fun Outcome; Action Step for "…will participate in activity" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2021.

7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.		

Standard of Care	Routine Survey Deficiencies May 17 – 28, 2021	Verification Survey New and Repeat Deficiencies January 3 – 13, 2022
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 # 1A43.1 General Events Reporting: Individual Reporting	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 19: Provider Reporting Requirements:** **19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap.	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 8 of 13 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within the required timeframe:** **Individual #1** • General Events Report (GER) indicates on 6/16/2020 the Individual tripped and left knee hit the ground while walking at the park. (Injury). GER was approved 6/22/2020. • General Events Report (GER) indicates on 11/30/2020 the Individual was tested for Covid-19. (Communicable Disease). GER was approved 12/3/2020. • General Events Report (GER) indicates on 1/12/2021 the Individual received their first dose of the Covid-19 vaccine. (Communicable Disease). GER was approved 1/19/2021. • General Events Report (GER) indicates on 2/9/2021 the Individual received their second dose of the Covid-19 vaccine. (Communicable Disease). GER was approved 2/15/2021. **Individual #2** • General Events Report (GER) indicates on 8/5/2020 the Individual cut his finger on a barb	**New / Repeat Finding:** Per the Plan of Correction approved on 9/13/2021, "Ongoing process to improve this tag will include running a report from Therap that has all Pending Approval GER's to ensure GER's are approved within 2 business days. Report will be sent out 2 x a week by Manager, monitored by Manager, and GER's will continue to be reported on at Weekly Case Contact." Documentation provided during the Verification Survey completed January 3 – 13, 2022, indicates report is not being sent out 2 times per week. The agency did not follow their Plan of Correction as agreed to.

4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat	wire fence that was rusted. (Injury). GER was approved 8/12/2020. • General Events Report (GER) indicates on 11/2/2020 the Individual was taken into the ER per RN to have swollen foot assessed. (Hospital). GER was approved 11/23/2020. • General Events Report (GER) indicates on 1/12/2021 the Individual received their first dose of the Covid-19 vaccine. (Communicable Disease). GER was approved 1/19/2021. • General Events Report (GER) indicates on 2/9/2021 the Individual received their second dose of the Covid-19 vaccine. (Communicable Disease). GER was approved 2/16/2021. **Individual #3** • General Events Report (GER) indicates on 3/16/2021 the Individual was taken into ER for psychiatric evaluation per physician. (Hospital). GER was approved 3/19/2021. • General Events Report (GER) indicates on 4/3/2021 the Individual called Law Enforcement asking for assistance because he heard his son on the roof. (Law Enforcement Involvement). GER was approved 4/9/2021. **Individual #4** • General Events Report (GER) indicates on 5/26/2020 the Individual had numerous bumps, bruises, and minor injuries on his face, arms, and chest. (ER Visit). GER was approved 6/1/2020. • General Events Report (GER) indicates on 5/26/2020 the Individual had numerous bumps, bruises, and minor injuries on his face, arms, and chest. (Injury). GER was approved 6/1/2020.	

Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.	• General Events Report (GER) indicates on 10/11/2020 the Individual had an abrasion on wrist. (Injury). GER was approved 11/9/2020. • General Events Report (GER) indicates on 1/6/2021 the Individual had small abrasion from rubbing his face. (Injury). GER was approved 1/13/2021. • General Events Report (GER) indicates on 3/3/2021 the Individual was eating breakfast and began to cough he refused to finish his breakfast. (Choking). GER was approved 3/10/2021. • General Events Report (GER) indicates on 3/21/2021 the Individual received their first dose of the Covid-19 vaccine. (Communicable Disease). GER was approved 4/13/2021. • General Events Report (GER) indicates on 4/7/2021 the Individual had a bruise after banging own hand against the window in the car because the individual couldn't open the toy. (Injury). GER was approved 4/13/2021. **Individual #5** • General Events Report (GER) indicates on 10/6/2020 the Individual stepped off the sidewalk, lost balance and scraped arm. (Injury). GER was approved 10/9/2020. • General Events Report (GER) indicates on 1/11/2021 the Individual was encouraged to be taken to the ER per RN to be evaluated for confusion and being lethargic. (Hospital). GER was approved 1/20/2021. • General Events Report (GER) indicates on 3/22/2021 the Individual stated her finger was hurting. (Injury). GER was approved 3/25/2021.	

	Individual #6 • General Events Report (GER) indicates on 5/18/2020 the Individual was self-harming and destroying property, RN approved use of PRN Psychotropic med. (PRN). GER was approved 6/4/2020. • General Events Report (GER) indicates on 6/1/2020 the Individual was threatening to destroy the neighbor's property, RN approved use of PRN Psychotropic med. (PRN). GER was approved 6/4/2020. • General Events Report (GER) indicates on 7/11/2020 the Individual had redness on her back. (Injury). GER was approved 7/28/2020. • General Events Report (GER) indicates on 7/13/2020 the Individual was sent to have Covid-19 testing. (Communicable Disease). GER was approved 7/17/2020. • General Events Report (GER) indicates on 8/3/2020 the Individual had a scratch on right butt and 2 small bruises under left forearm. (Injury). GER was approved 08/07/2020. • General Events Report (GER) indicates on 8/4/2020 the Individual was getting nails trimmed as she moved staff accidently snipped a piece of skin. (Injury). GER was approved 8/7/2020. • General Events Report (GER) indicates on 8/5/2020 the Individual had a small bruise on right upper leg. (Injury). GER was approved 8/10/2020. • General Events Report (GER) indicates on 8/15/2020 the Individual had redness on right leg shin area due to scratching because it itched. (Injury). GER was approved 8/21/2020.	

	• General Events Report (GER) indicates on 8/25/2020 the Individual had redness on forehead from scratching. (Injury). GER was approved 8/31/2020. • General Events Report (GER) indicates on 9/1/2020 the Individual noticed mark on right arm. (Injury). GER was approved 9/8/2020. • General Events Report (GER) indicates on 9/3/2020 the Individual had a bruise on right knee. (Injury). GER was approved 9/8/2020. • General Events Report (GER) indicates on 9/16/2020 the Individual had a bruise on right upper thigh. (Injury). GER was approved 9/28/2020. • General Events Report (GER) indicates on 9/23/2020 the Individual had a bruise right outer arm. (Injury). GER was approved 9/30/2020. • General Events Report (GER) indicates on 9/26/2020 the Individual had a scratch on left hip. (Injury). GER was approved 10/02/2020. • General Events Report (GER) indicates on 11/12/2020 the Individual tripped and got a scrape on left knee. (Injury). GER was approved 11/30/2020. • General Events Report (GER) indicates on 4/5/2021 the Individual had scratches on back from scratching it. (Injury). GER was approved 4/16/2021. • General Events Report (GER) indicates on 4/8/2021 the Individual registered for the first dose of Covid-19 Vaccine. (Communicable Disease). GER was approved 4/30/2021.	

	• General Events Report (GER) indicates on 4/28/2021 the Individual had a quarter sized bruise on left knee. (Injury). GER was approved 5/3/2021. **Individual #7** • General Events Report (GER) indicates on 11/5/2020 the Individual had 2 dime sized bruises on right arm. (Injury). GER was approved 11/10/2020. **Individual #8** • General Events Report (GER) indicates on 4/8/2021 the Individual received first dose of the Covid-19 Vaccine. (Communicable Disease). GER was approved 4/13/2021. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #7** • Documentation reviewed indicates on 5/9/2021 the Individual received a Covid-19 PCR test at hospital (neg). (Communicable disease). No GER was found.	

Standard of Care	Routine Survey Deficiencies May 17 – 28, 2021	Verification Survey New and Repeat Deficiencies January 3 – 13, 2022
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 # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	**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 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-	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 11 of 13 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Comprehensive Aspiration Risk Management Plan*:*** ➢ Not linked/attached in Therap (#1) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Not linked/attached in Therap (#5) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Healthcare Passport:** ➢ Did not contain Emergency Contact Information (#1, 2, 3, 8, 12) *(Note: Health Passport corrected during on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Did not contain Guardianship/Healthcare Decision Maker (#2, 4, 10, 12, 13) *(Note: Health*	**Repeat Finding:** Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 12 individuals Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Medical Emergency Response Plans:** ***GERD*** • Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services. **Chapter 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),	*Passport corrected during on-site survey. Provider please complete POC for ongoing QA/QI.)* ➢ Did not contain Name of Physician, (#12) *(Note: Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Health Care Plans:** ***Colonized/Infected with multidrug:*** • Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. ***Diabetes:*** • Individual #11 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. ***Infection Control (Is immunocompromised):*** • Individual #5 - According to Electronic Comprehensive Health Assessment Tool 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.)* ***Respiratory/Asthma:*** • Individual #11 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Evidence indicated the plan was not current. ***Respiratory (treatment or equipment):*** • Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. *(Note: Linked / attached*	

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 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.	*in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* **Medical Emergency Response Plans:** ***Aspiration Risk:*** • Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ***Colonized/Infected with multidrug:*** • Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. Not Linked or Attached in Therap. ***Diabetes:*** • Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. *(Note: Completed and Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Falls*** • Individual #9 - According to Electronic Comprehensive Health Assessment Tool 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.)* • Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	

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	***GERD*** • Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Impaired Neurological Status*** • Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ***Infection Control (Is immunocompromised):*** • Individual #1 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Individual #5 - According to Electronic Comprehensive Health Assessment Tool 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.)* ***Respiratory (treatment or equipment):*** • Individual #5 - According to Electronic Comprehensive Health Assessment Tool 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.)* ***Respiratory/Asthma:*** • Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. *(Note: Completed and Linked / attached in Therap during the on-site survey. Provider please complete POC for ongoing QA/QI.)* ***Urinary Incontinence:***	

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	• Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	

to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary report which is indicated by "R" in the HCP column. At the nurse's sole discretion, based on prudent nursing practice, HCPs may be combined where clinically appropriate. The nurse should use nursing judgment to determine whether to also include HCPs for any of the areas indicated by "C" on the e-CHAT summary report. The nurse may also create other HCPs plans that the nurse determines are warranted. ***13.2.10 Medical Emergency Response Plan (MERP):*** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation. **Chapter 20: Provider Documentation and Client Records: 20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport		

and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form.		

Tag # 1A31 Client Rights / Human Rights	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019	After an analysis of the evidence, it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 13 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Positive Behavior Support Plan "Levels Program - Restitution." No evidence found of Human Rights Committee approval. (Individual #6) • Positive Behavior Support Plan "Levels Program – 911." No evidence found of Human Rights Committee approval. (Individual #10)	**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 ensure the rights of Individuals was not restricted or limited for 1 of 12 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. <u>No documentation</u> was found regarding Human Rights Approval for the following: • Positive Behavior Support Plan "Levels Program – 911." No evidence found of Human Rights Committee approval. (Individual #10) *(Note: HRC Approval obtained during the on-site survey. Provider please complete POC for ongoing QA/QI)*

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

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

that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy		

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

Standard of Care	Routine Survey Deficiencies May 17 – 28, 2021	Verification Survey New and Repeat Deficiencies January 3 – 13, 2022
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 # 1A08.3 Administrative Case File: Individual Service Plan / ISP Components	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Condition of Participation 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 # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**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 # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	**Standard 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 # IS25 Community Integrated Employment Services	**Standard Level Deficiency**	**COMPLETE**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 Supported Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag #IH32 Customized In-Home Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Completion Date
Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	**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 # 1A43.1 General Events Reporting: Individual Reporting	**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?)*: →	
Tag # 1A31 Client Rights / Human Rights	**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: September 7, 2022

To: Analisa Martinez, Community Support Services Director

Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: amartinez@trescoinc.org

Region: Southwest
Routine Survey: May 17 – 28, 2021
Verification Survey: January 3 – 13, 2022

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Supported Living; Customized In-Home Supports; Customized Community Supports, and Community Integrated Employment Services

Survey Type: Verification

Dear Ms. Martinez:

The Division of Health Improvement/Quality Management Bureau received notification that as of September 1, 2022, your agency is no longer providing Developmental Disabilities Waiver services for the State of New Mexico. The Plan of Correction process with the Quality Management Bureau was not complete, however due to your provider status:

The Plan of Correction process is now closed.

Thank you for your cooperation and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Monica Valdez, BS

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

Q.22.3.DDW.D1135.3.VER.09.22.250