



Date: September 10, 2012

To: Larry Maxey, Executive Director  
 Provider: Alegria Family Services, Inc.  
 Address: 1020 Coal Ave. SE  
 State/Zip: Albuquerque, New Mexico 87106

E-mail Address: [Larry@alegriafamily.com](mailto:Larry@alegriafamily.com)

Region: Metro  
 Survey Date: August 6 - 9, 2012  
 Program Surveyed: Developmental Disabilities Waiver  
 Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation & Community Access)

Survey Type: Routine  
 Team Leader: Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
 Team Members: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Erica Nilsen, BA Division of Health Improvement/Quality Management Bureau

Dear Mr. Maxey:

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

**Determination of Compliance:**

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

***Compliance with all Conditions of Participation.***

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

**Plan of Correction:**

The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your



**DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU**  
 5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
 (505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Alegria Family Services, Inc. – Metro, August 6 - 9, 2012

agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

**Submission of your Plan of Correction:**

Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. (See attachment "A" for additional guidance in completing the Plan of Correction).

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

- 1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Request for Informal Reconsideration of Findings (IRF):**

If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief  
5301 Central Ave NE Suite #400  
Albuquerque, NM 87108  
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-699-9356 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,

*Marti Madrid, LBSW*

Marti Madrid, LBSW  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date:	August 6, 2012
Present:	<b><u>Alegria Family Services, Inc.</u></b> Paola Ramirez, Office Manager, Chief Financial Officer Carl Dellinger, Service Coordinator  <b><u>DOH/DHI/QMB</u></b> Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor
Exit Conference Date:	August 9, 2012
Present:	<b><u>Alegria Family Services, Inc.</u></b> Larry Maxey, Director Paola Ramirez, Office Manager, Chief Financial Officer Michelle Mills, Service Coordinator Shannon Benavides, RN Michael Beltran, Service Coordinator Andrea Newberry, Service Coordinator Latisha Samora, Quality Assurance Manager  <b><u>DOH/DHI/QMB</u></b> Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Jennifer Bruns, BSW, Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor
Total Homes Visited	Number: 7
❖ Supported Homes Visited	Number: 2
❖ Family Homes Visited	Number: 5
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 11 0 - <i>Jackson</i> Class Members 11 - <i>Non-Jackson</i> Class Members 4 - Supported Living 5 - Family Living 1 - Independent Living 5 - Adult Habilitation 2 - Community Access
Persons Served Records Reviewed	Number: 11
Persons Served Interviewed	Number: 6
Persons Served Observed	5 (Two Individuals were observed and 3 other Individuals were not available during on-site survey.)
Direct Support Personnel Interviewed	Number: 14
Direct Support Personnel Records Reviewed	Number: 109

Service Coordinator Records Reviewed

Number: 6

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- 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

## **Attachment A**

### **Provider Instructions for Completing the QMB Plan of Correction (POC) Process**

#### ***Introduction:***

After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 business days will be referred to the Internal Review Committee [IRC] for possible actions or sanctions).

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings. (Providers who fail to complete a POC within the 45 business days allowed shall be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-699-9356 or email at [Crystal.Lopez-Beck@state.nm.us](mailto:Crystal.Lopez-Beck@state.nm.us). Requests for technical assistance must be requested through your DDSD Regional Office.

The POC process cannot resolve disputes regarding findings. If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) business days of receiving your report. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

#### ***Instructions for Completing Agency POC:***

##### ***Required Content***

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan.

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

##### ***The Plan of Correction must address the required six CMS core elements to address each deficiency of the POC:***

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
  6. The POC must be signed and dated by the agency director or other authorized official.

*The following details should be considered when developing your POC:*

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
- Your process for gathering, analyzing and responding to Quality data; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

**Note: Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

#### **Completion Dates**

- The plan of correction must include a **completion date** (entered in the far right-hand column) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

#### **Initial Submission of the Plan of Correction Requirements**

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
  - a. Electronically at [Crystal.Lopez-Beck@state.nm.us](mailto:Crystal.Lopez-Beck@state.nm.us) (*preferred method*)
  - b. Fax to 505-222-8661, or
  - c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

- a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
  - c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

### ***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

## 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) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. 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.
- “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 one (1) to three (3) ‘Conditions of Participation.’ 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).

Providers receiving a repeat determination of ‘Partial-Compliance’ for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Non-Compliant 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 and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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.



**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 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 IRC process, email the IRF Chairperson, Scott Good at [scott.good@state.nm.us](mailto:scott.good@state.nm.us) for assistance.

**The following limitations apply to the IRF process:**

- The 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 made 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:** Alegria Family Services, Inc. - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation & Community Access)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** August 6 – 9, 2012

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<b>CMS Assurance – Service Plans: ISP Implementation</b> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.			
<b>Tag # 1A08 Agency Case File</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>D. Provider Agency Case File for the Individual:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:            (1) Emergency contact information, including the</p>	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 2 of 11 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Occupational Therapy Plan (#5)</li> <li>• <b>Auditory Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 12/23/10. Follow-up was to be completed in one year. No evidence of follow-up found.</li> </ul> </li> <li>• <b>Mammogram Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - As indicated by the ISP, the exam is to be annually, no evidence of exam found.</li> </ul> </li> </ul>	<p><b>Provider:</b>            State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b>            Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	<p>  </p>

<p>individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>			
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**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

**B. Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

<b>Tag # 6L14 Residential Case File</b>	<b>Standard Level Deficiency</b>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>A. Residence Case File:</b> For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:</p> <ul style="list-style-type: none"> <li>(1) Complete and current ISP and all supplemental plans specific to the individual;</li> <li>(2) Complete and current Health Assessment Tool;</li> <li>(3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</li> <li>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</li> <li>(5) Data collected to document ISP Action Plan implementation</li> </ul>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 9 Individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Occupational Therapy Plan (#5 &amp; 8)</li> <li>• Physical Therapy Plan (#2 &amp; 8)</li> <li>• <b>Special Health Care Needs</b> <ul style="list-style-type: none"> <li>◦ Nutritional Plan (#8)</li> <li>◦ CARMP (#2 &amp; 8)</li> <li>◦ Tube Feeding Protocol (#2)</li> <li>◦ Oral Care (#2)</li> </ul> </li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>◦ Aspiration (#2 &amp; 8)</li> <li>◦ Diabetes (#8)</li> </ul> </li> <li>• <b>Crisis Plan/Medical Emergency Response Plans</b> <ul style="list-style-type: none"> <li>◦ Allergies (#8)</li> <li>◦ Cardiac Condition (#10)</li> </ul> </li> </ul>	<p><b>Provider:</b>  State your Plan of Correction for the deficiencies cited in this tag here: →</p>             <p><b>Provider:</b>  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	             

<p>(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> <li>(a) The name of the individual;</li> <li>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;</li> <li>(c) Diagnosis for which the medication is prescribed;</li> <li>(d) Dosage, frequency and method/route of delivery;</li> <li>(e) Times and dates of delivery;</li> <li>(f) Initials of person administering or assisting with medication; and</li> <li>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</li> <li>(h) For PRN medication an explanation for the use of the PRN must include: <ul style="list-style-type: none"> <li>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</li> <li>(ii) Documentation of the effectiveness/result of the PRN delivered.</li> </ul> </li> <li>(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated</li> </ul>			
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<p>copy must be placed in the agency file on a weekly basis.</p> <p>(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and</p> <p>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.</p>			
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><b>CMS Assurance – Qualified Providers</b> – 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.</p>			
<p><b>Tag # 1A11.1 Transportation Training</b></p>	<p><b>Standard Level Deficiency</b></p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards...</p> <p><b>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date:</b> March 1, 2007</p> <p><b>II. POLICY STATEMENTS:</b></p> <p>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:</p> <ol style="list-style-type: none"> <li>1. Operating a fire extinguisher</li> <li>2. Proper lifting procedures</li> <li>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)</li> <li>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines</li> </ol>	<p>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 10 of 109 Direct Support Personnel.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> <li>• Transportation (DSP #44, 46, 56, 79, 101, 102, 106, 108, 131 &amp; 115)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	<p>  </p>



<p>for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)</p> <p>5. Operating wheelchair lifts (if applicable to the staff's role)</p> <p>6. Wheelchair tie-down procedures (if applicable to the staff's role)</p> <p>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</p>			
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<p><b>Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</b></p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p> <p>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</p> <p>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</p> <p>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</p> <p>G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.</p> <p>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</p> <p>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.</p>			
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<p>individual;</p> <p>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p><b>Department of Health (DOH) Developmental</b></p>			
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**Disabilities Supports Division (DDSD) Policy**  
**- Policy Title: Training Requirements for**  
**Direct Service Agency Staff Policy - Eff.**  
**March 1, 2007 - II. POLICY STATEMENTS:**  
A. Individuals shall receive services from  
competent and qualified staff.



<p>sexual contact, incest, indecent exposure, or other related felony sexual offenses;</p> <p><b>E.</b> crimes involving adult abuse, neglect or financial exploitation;</p> <p><b>F.</b> crimes involving child abuse or neglect;</p> <p><b>G.</b> crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</p> <p><b>H.</b> an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</p>			
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Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	Standard Level Deficiency		
<p><b>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</b> 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.</p> <p>A. <b>Provider requirement to inquire of registry.</b> 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.</p> <p>B. <b>Prohibited employment.</b> 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.</p> <p>D. <b>Documentation of inquiry to registry.</b> The provider shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 2 of 115 Agency Personnel.</p> <p><b>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</b></p> <p><b>Direct Support Personnel (DSP):</b></p> <ul style="list-style-type: none"> <li>• #69 – Date of hire 2/1/2011, completed 2/25/2011.</li> <li>• #77 – Date of hire 9/23/2011, completed 10/3/2011.</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>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.</p> <p>E. <b>Documentation for other staff.</b> 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.</p> <p>F. <b>Consequences of noncompliance.</b> 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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>Chapter 1.IV. General Provider Requirements. D. Criminal History Screening:</b> All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and</p>			
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Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency		
<p><b>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</b></p> <p><b>A. General:</b> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</p> <p><b>E. Consumer and Guardian Orientation Packet:</b> Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 1 of 11 individuals.</p> <ul style="list-style-type: none"><li>• Parent/Guardian Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#6)</li></ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><b>CMS Assurance – Health and Welfare</b> – <i>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.</i></p>			
<p><b>Tag # 1A03 CQI System</b></p>	<p><b>Standard Level Deficiency</b></p>		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007  <b>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</b>  <b>I. Continuous Quality Management System:</b>  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;  (4) Trends in medication and medical incidents leading to adverse health</p>	<p>Based on record review and interview, the Agency failed to implement their Continuous Quality Management System as required by standard.</p> <p>The following was not found, not current and or incomplete:</p> <ul style="list-style-type: none"> <li>• The Agency’s Continuous Quality Improvement Plan provided during the on-site survey (8/6/12) was not dated. No evidence was found indicating when the document had been created.</li> <li>• The Agency’s CQI Plan did not contain the following components: <ol style="list-style-type: none"> <li>(1) Individual access to needed services and supports;</li> <li>(2) Effectiveness and timeliness of implementation of Individualized Service Plans;</li> <li>(3) Trends in achievement of individual outcomes in the Individual Service Plans;</li> <li>(4) Trends in medication and medical incidents leading to adverse health events;</li> <li>(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</li> <li>(6) Quality and completeness documentation;</li> </ol> </li> </ul>	<p><b>Provider:</b>  State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b>  Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>events;</p> <p>(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</p> <p>(6) Quality and completeness documentation; and</p> <p>(7) Trends in individual and guardian satisfaction.</p> <p><b>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</b></p> <p><b>E. Quality Improvement System for Community Based Service Providers:</b> 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:</p> <p>(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;</p> <p>(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;</p> <p>(4) community based service providers</p>			
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<p>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.</p>			
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Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 <b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>E. Medication Delivery:</b> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</p> <p>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</p> <p>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</p> <p>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</p>	<p>Medication Administration Records (MAR) were reviewed for the months of May and June, 2012</p> <p>Based on record review, 5 of 11 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</p> <p>Individual #3 June 2012 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Baclofen 20 mg (4 times daily) - Blank 6/15 4 PM</li> <li>• Docusate Sodium 100 mg (2 times daily) – Blank 6/9 &amp; 30 PM</li> <li>• Fluticason Prop 25mg (2 times daily) – Blank 6/19 PM</li> <li>• Oyster Shell Calcium 500 mg (2 times daily) – Blank 6/24 PM</li> </ul> <p>Individual #6 May 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Azithromycin 250mg</li> <li>• Quetiapine (Seroquel) 50mg</li> </ul> <p>Medication Administration Records did not contain the route of administration for the following medications:</p> <ul style="list-style-type: none"> <li>• Azithromycin 250mg</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	



<p>(c) Initials of the individual administering or assisting with the medication;</p> <p>(d) Explanation of any medication irregularity;</p> <p>(e) Documentation of any allergic reaction or adverse medication effect; and</p> <p>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</p> <p>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;</p> <p>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;</p> <p>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;</p> <p><b>NMAC 16.19.11.8 MINIMUM STANDARDS:</b>  <b>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:</b></p> <p>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, <b>including over-the-counter medications.</b> This documentation shall include:</p> <p>(i) Name of resident;</p> <p>(ii) Date given;</p>	<p>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Check O2 saturation with monitor in am and pm – Blank 5/27, 28 &amp; 29 (AM &amp; PM).</li> <li>• G-tube care apply topically daily - Blank 5/30 (2PM &amp; 8PM)</li> </ul> <p>June 2012  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Trazodone 100 mg(1 time daily) – Blank 6/17</li> <li>• CPAP apply mask every night and turn on machine – Blank 6/25, 26 27 &amp; 30.</li> <li>• Check O2 saturation with monitor in am and pm – Blank 6/5 &amp; 25 (AM) &amp; 6/19 (PM).</li> <li>• Diphenhydramine 2% cream (2 times daily) Blank 6/6 (AM)</li> <li>• Clotrimazole Bethamethazone (2 times daily) – Blank 6/6 (AM)</li> <li>• Citalopram (Celexa) 20 mg (1 time daily) – Blank 6/5</li> </ul> <p>Individual #8  May 2012  Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Prilosec OTC 20 mg (1 time daily)</li> <li>• Oyster Shell Cal 500 mg (1 time daily)</li> </ul>		
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<ul style="list-style-type: none"> <li>(iii) Drug product name;</li> <li>(iv) Dosage and form;</li> <li>(v) Strength of drug;</li> <li>(vi) Route of administration;</li> <li>(vii) How often medication is to be taken;</li> <li>(viii) Time taken and staff initials;</li> <li>(ix) Dates when the medication is discontinued or changed;</li> <li>(x) The name and initials of all staff administering medications.</li> </ul> <p><b>Model Custodial Procedure Manual</b>  <b>D. Administration of Drugs</b>  Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.  Document the practitioner's order authorizing the self-administration of medications.</p> <p>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:</p> <ul style="list-style-type: none"> <li>➤ symptoms that indicate the use of the medication,</li> <li>➤ exact dosage to be used, and</li> <li>➤ the exact amount to be used in a 24 hour period.</li> </ul>	<ul style="list-style-type: none"> <li>• Abilify 15 MG (1 time daily)</li> <li>• Benadryl 50mg (1 time daily)</li> <li>• Prozac 40mg (1 time daily)</li> <li>• Baclofen 10mg (2 times a day)</li> <li>• Baclofen 10mg (1 time daily)</li> </ul> <p>June 2012  Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</p> <ul style="list-style-type: none"> <li>• Diazepam 5mg (1 time daily) – Blank 6/9</li> <li>• Trazodone 100mg (1 time daily) – Blank 6/9</li> </ul> <p>Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Diazepam 5 mg (1 time daily)</li> <li>• Prilosec OTC 20 mg (1 time daily)</li> <li>• Oyster Shell Cal 500 mg (1 time daily)</li> <li>• Abilify 10 MG (1 time daily)</li> <li>• Prozac 40mg (1 time daily)</li> </ul> <p>Individual #10  May 2012  Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Oxcarbazapine 150mg (2 times daily)</li> </ul> <p>Individual #11</p>		
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	<p>May 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Dexedrine 15mg (1 time daily)</li> <li>• Ranitidine 150mg (2 times daily)</li> <li>• Abilify 20mg (2 times daily)</li> <li>• Citalopram 40mg (1 time daily)</li> <li>• Lamotegrine 25mg (4 times daily)</li> </ul> <p>June 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</p> <ul style="list-style-type: none"> <li>• Dexteroamphet 15mg (1 time daily)</li> <li>• Ranitidine 150mg (2 times daily)</li> <li>• Abilify 20mg (2 times daily)</li> <li>• Citalopram 40mg (1 time daily)</li> <li>• Lamotrigrine 25mg (4 times daily)</li> <li>• Vitamin D 1000 IU (1 time daily)</li> </ul>		
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<p>assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.</p> <p>(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.</p> <p>(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).</p> <p>(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,</p>	<ul style="list-style-type: none"> <li>◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</li> <li>◦ <i>Cardiac Condition</i></li> <li>◦ Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</li> </ul>		
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<p>method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p><b>(2) Health related plans</b></p> <p>(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.</p> <p>(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.</p> <p>(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):</p> <p>(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain</p>			
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<p>a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.</p> <p>(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.</p> <p>(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.</p>			
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<p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p><b>(4) General Nursing Documentation</b></p> <p>(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.</p> <p>(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>B. IDT Coordination</b></p> <p>(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and</p> <p>(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.</p>			
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**Department of Health Developmental  
Disabilities Supports Division Policy.  
Medical Emergency Response Plan Policy  
MERP-001 eff.8/1/2010**

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.

Tag # 6L13 Community Living Healthcare Reqts.	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</b></p> <p><b>G. Health Care Requirements for Community Living Services.</b></p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as</p>	<p>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 9 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>Auditory Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #1 - As indicated by collateral documentation, exam was completed 5/27/10. Doctor ordered annual hearing evaluations. No evidence annual evaluation found.</li> </ul> </li> <li>• <b>Blood Levels</b> <ul style="list-style-type: none"> <li>◦ Individual #3 - As indicated by collateral documentation reviewed, lab work was ordered on 10/12/2011. No evidence of lab results was found.</li> <li>◦ Individual #8 - As indicated by collateral documentation reviewed, lab work was ordered on 11/15/2011. No evidence of lab results was found.</li> </ul> </li> <li>• <b>Neurology Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #3 – As indicated by collateral documentation reviewed, exam was to be scheduled. No evidence of exam being completed was found.</li> </ul> </li> <li>• <b>Gastrointestinal Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #3 - As indicated by collateral documentation reviewed, exam was to be scheduled. No evidence of exam being completed was found.</li> </ul> </li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	

<p>detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>			
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**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

**A** provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

**B. Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>L. Residence Requirements for Family Living Services and Supported Living Services</b></p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <p>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</p> <p>(b) General-purpose first aid kit;</p> <p>(c) When applicable due to an individual's health status, a blood borne pathogens kit;</p> <p>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</p> <p>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</p> <p>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</p> <p>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and</p> <p>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence</p>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 3 of 7 Supported Living &amp; Family Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p><b>Supported Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#3 &amp; 6)</li> </ul> <p><i>Note: Individuals #3 &amp; 6 share a residence.</i></p> <p><b>Family Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1 &amp; 10)</li> </ul>	<p><b>Provider:</b> State your Plan of Correction for the deficiencies cited in this tag here: →</p> <p><b>Provider:</b> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</p>	<p>  </p>

unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
<p><b>CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability</b> – <i>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i></p>			
<p><b>TAG #1A12 All Services Reimbursement (No Deficiencies)</b></p>			
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 <b>Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</b></p> <p><b>B. Billable Units:</b> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</p> <ul style="list-style-type: none"> <li>(1) Date, start and end time of each service encounter or other billable service interval;</li> <li>(2) A description of what occurred during the encounter or service interval; and</li> <li>(3) The signature or authenticated name of staff providing the service.</li> </ul> <p>Billing for Community Living (Supported Living, Family Living &amp; Independent Living) and Community Inclusion (Adult Habilitation &amp; Community Access) services was reviewed for 11 of 11 individuals. <i>Progress notes and billing records supported billing activities for the months of April, May and June 2012.</i></p>			



Date: November 20, 2012

To: Larry Maxey, Executive Director  
Provider: Alegria Family Services, Inc.  
Address: 1020 Coal Ave. SE  
State/Zip: Albuquerque, New Mexico 87106

E-mail Address: [Larry@alegriafamily.com](mailto:Larry@alegriafamily.com)

Region: Metro  
Survey Date: August 6 - 9, 2012  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Community Living Supports (Supported Living, Family Living & Independent Living) & Community Inclusion Supports (Adult Habilitation & Community Access)  
Survey Type: Routine

Dear Mr. Maxey:

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

**The Plan of Correction process is now complete.**

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

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

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

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

Sincerely,

  
Crystal Lopez-Beck  
Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.13.2.DDW.91080509.5.001.RTN.09.325

