Dear Ms. Karcz,

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
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,

_Nadine Romero, LBSW_

Nadine Romero, LBSW  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau


Survey Report #: Q.13.2/DDW.D4051.5.001.RTN.01.345
Survey Process Employed:

Entrance Conference Date: November 13, 2012

Present:

**A Better Way of Living, Inc.**
- Tom Reyes, Independent Living Director
- Susan Karcz, Director
- Nick Harada, Program Manager
- Chris Johnson, Program Director
- Christine Gonzales, Program Support Specialist

**DOH/DHI/QMB**
- Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
- Cynthia Nielsen, RN, MSN, Healthcare Surveyor
- Corrina Strain, RN, Healthcare Surveyor
- Nicole Brown, MBA, Healthcare Surveyor

Exit Conference Date: November 15, 2012

Present:

**A Better Way of Living, Inc.**
- Susan Karcz, Director
- Tom Reyes, Independent Living Director
- Chris Johnson, Program Director
- John Noel, Employment/Training Director
- Nick Harada, Program Manager
- Samantha Williams, Service Coordinator
- Michael Hochron, Adult Habilitation Services Director

**DOH/DHI/QMB**
- Nadine Romero, LBSW, Team Lead/Healthcare Surveyor
- Nicole Brown, MBA, Healthcare Surveyor

- **Total Homes Visited Number:** 4
- **Supported Homes Visited Number:** 4

- **Administrative Locations Visited Number:** 1

- **Total Sample Size Number:** 11
  - 2 - *Jackson* Class Members
  - 9 - Non-*Jackson* Class Members
  - 5 - Supported Living
  - 2 - Independent Living
  - 7 - Adult Habilitation
  - 9 - Supported Employment

- **Persons Served Records Reviewed Number:** 11
- **Persons Served Interviewed Number:** 11
- **Direct Support Personnel Interviewed Number:** 14
- **Direct Support Personnel Records Reviewed Number:** 63
- **Service Coordinator Records Reviewed Number:** 4
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. 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 (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108

Survey Report #: Q.13.2/DDW.D4051.5.001.RTN.01.345
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.
Attachment B

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

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

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

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

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

Case Management Services:
- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:
- Qualified Provider
- Plan of Care
- Health, Welfare & Safety

Conditions of Participation (CoPs)

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

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team’s analysis establishes that there is an identified
potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

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

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

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

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

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

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

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

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

**Service Domain: Plan of Care**  
Condition of Participation:  
5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

**Service Domain: Health, Welfare & Safety**  
Condition of Participation:  
6. **Individual Health, Safety and Welfare**: Individuals have the right to live and work in a safe environment.

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

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

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

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

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

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

**Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**

**CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** 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.

**D. Provider Agency Case File for the Individual:** 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

### Deficiencies

Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 2 of 11 individuals.

Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:

- **Positive Behavioral Crisis Plan (#6)**
- **Documentation of Guardianship/Power of Attorney (#6 & 10)**
- **Dental Exam**
  - Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
- **Vision Exam**
  - Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.

### Agency Plan of Correction, On-going QA/QI & Responsible Party

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here:

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:

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Survey Report #: Q.13.2.DDW.D4051.5.001.RTN.01.345
| **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;** | **Review of Psychotropic Medication**  
- Individual #6 - According to ISP Individual #6 is to have a medication review every, 6-months. No evidence was found for the following time frame to indicate they were completed for 5/2012 – 10/2012. |
| (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); | **Abnormal Involuntary Movement Screening and Tardive Dyskinesia Screenings**  
- None found 8/2012 – 10/2012 for Zyprexa (#6) |
| (3) Progress notes and other service delivery documentation; |  |
| (4) Crisis Prevention/Intervention Plans, if there are any for the individual; |  |
| (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; |  |
| (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 |  |
| (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. |  |
| (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: |  |
| (a) Complete file for the past 12 months; |  |
| (b) ISP and quarterly reports from the current and prior ISP year; |  |
| (c) Intake information from original admission to services; and |  |
| (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School |  |
School or Ft. Stanton Hospital.

**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.
<table>
<thead>
<tr>
<th>Tag # 6L14 Residential Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 3 of 5 Individuals receiving Supported Living Services. The following was not found, incomplete and/or not current:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>
| CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS | - [Current Emergency & Personal Identification Information](#)  
  ° Did not contain Health Plan Information (#11)  
  - Positive Behavioral Crisis Plan (#7)  
  - Speech Therapy Plan (#5)  
  - Special Health Care Needs  
    ° Nutritional Plan (#11)  
  - Health Care Plans  
    ° Oral Hygiene (#11) | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| A. Residence Case File: 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:  
(1) Complete and current ISP and all supplemental plans specific to the individual;  
(2) Complete and current Health Assessment Tool;  
(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;  
(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);  
(5) Data collected to document ISP Action Plan |
(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;

(7) Physician’s or qualified health care providers written orders;

(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);

(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (a) The name of the individual;
   (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
   (c) Diagnosis for which the medication is prescribed;
   (d) Dosage, frequency and method/route of delivery;
   (e) Times and dates of delivery;
   (f) Initials of person administering or assisting with medication; and
   (g) An explanation of any medication irregularity, allergic reaction or adverse effect.

(h) For PRN medication an explanation for the use of the PRN must include:
   (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
   (ii) Documentation of the effectiveness/result of the PRN delivered.

(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 copy must be placed in the agency file on a weekly basis.

(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

(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.
### Standard of Care

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>CMS Assurance – Qualified Providers</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 24 of 63 Direct Support Personnel. No documented evidence was found of the following required training:  
- Transportation (DSP #40, 42, 43, 45, 47, 52, 53, 61, 63, 64, 65, 67, 68, 72, 74, 77, 85, 86, 89, 97, 98, 99, 101, &102)                                                                                      | 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. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |          |

### Tag # 1A11.1 Transportation Training

**Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**

**CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** 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...

**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date:** March 1, 2007

**II. POLICY STATEMENTS:**

1. 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:
   1. Operating a fire extinguisher
   2. Proper lifting procedures
   3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)
   4. Assisting passengers with cognitive and/or...
physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff’s role)
6. Wheelchair tie-down procedures (if applicable to the staff’s role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
### TAG #1A20  Direct Support Personnel Training

<table>
<thead>
<tr>
<th>Tag #1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 36 of 63 Direct Support Personnel.</td>
<td></td>
</tr>
</tbody>
</table>

**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.

**C. Orientation and Training Requirements:**

Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:

1. Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and
2. Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.

Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 36 of 63 Direct Support Personnel.

Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:

- First Aid (DSP #51, 55, 57, 60, 61, 76, 84, 89, & 94)
- CPR (DSP #51, 55, 57, 60, 61, 76, 84, 89, & 94)
- Assisting With Medication Delivery (DSP #41, 43, 46, 47, 49, 50, 53, 54, 66, 67, 68, 69, 70, 71, 72, 81, 82, 83, 85, 86, 89, 90, 96, 98, 99, 100, 101, & 102)
- Positive Behavior Supports Strategies (DSP #101)

**Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

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Survey Report #: Q.13.2.DDW.D4051.5.001.RTN.01.345
<table>
<thead>
<tr>
<th>Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
</tr>
<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
### Tag # 1A22 Agency Personnel Competency

**Standard Level Deficiency**

Based on interview, the Agency failed to ensure that training competencies were met for 1 of 14 Direct Support Personnel.

**When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:**

- DSP #53 stated, “Yes, it covers strengthen knees and cardio vascular.” According to the ISP and the budget the Individual does not have an Occupational Therapy Plan. (Individual #8)

**Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: →

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

<table>
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<tr>
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<tbody>
<tr>
<td><strong>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</strong> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
</tr>
<tr>
<td><strong>F. Qualifications for Direct Service Personnel:</strong> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</td>
</tr>
<tr>
<td>(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;</td>
</tr>
<tr>
<td>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</td>
</tr>
<tr>
<td>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the</td>
</tr>
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</table>
individual;

(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

(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.

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:
(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;
(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and
(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.
A. Individuals shall receive services from competent and qualified staff.
<table>
<thead>
<tr>
<th>Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:</strong> 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.</td>
<td>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 3 of 63 Agency Personnel. The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>A. Provider requirement to inquire of registry.</strong> 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.</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td><strong>B. Prohibited employment.</strong> 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.</td>
<td>• #47 – Date of hire 4/5/2012, completed 4/14/2010.</td>
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</tr>
<tr>
<td><strong>D. Documentation of inquiry to registry.</strong> 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</td>
<td>• #82 – Date of hire 7/9/2012, completed 7/29/2012</td>
<td></td>
</tr>
</tbody>
</table>
documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

**E. Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual’s current licensure as a health care professional or current certification as a nurse aide.

**F. Consequences of noncompliance.**
The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.


**Chapter 1.IV. General Provider Requirements.**

**D. Criminal History Screening:** 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 Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 10 of 67 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here:</td>
</tr>
</tbody>
</table>
| A. General: 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. | Direct Support Personnel (DSP):  
- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#42, 44, 58, 65, 66, 75, 78, 86, &102) | |
| D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. | Service Coordination Personnel (SC):  
- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#104) | |
| Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS: | | |
competent and qualified staff.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 1A37 Individual Specific Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 3 of 67 Agency Personnel. Review of personnel records found no evidence of the following: <strong>Direct Support Personnel (DSP):</strong> - Individual Specific Training (#86, 95 &amp; 101)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td></td>
<td></td>
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<tr>
<td>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (2) <strong>Individual-specific training</strong> for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
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</tr>
<tr>
<td>Department of Health (DOH) Developmental 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. B. Staff shall complete individual-specific</td>
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Survey Report #: Q.13.2.DDW.D4051.5.001.RTN.01.345
(formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
CMS Assurance – 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.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>QA/QI Plan</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>DD Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review the Agency failed to implement their Continuous Quality Management System as required by standard.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Developmental Disabilities (DD) Waiver</td>
<td>• Review of the findings identified during the on-site survey 11/13 – 16, 2012 and as reflected in this report of findings the Agency had multiple deficiencies noted, which indicates the QA/QI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.</td>
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<td></td>
<td>Providers:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</table>
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;
(6) Quality and completeness documentation; and
(7) Trends in individual and guardian satisfaction.

### 7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:

#### E. Quality Improvement System for Community Based Service Providers:
The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

1. Community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
2. Community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A09   Medication Delivery (MAR)</th>
<th>Standard Level Deficiency</th>
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</thead>
<tbody>
<tr>
<td>1A09 Medication Delivery (MAR) - Routine Medication</td>
<td>Medication Administration Records (MAR) were reviewed for the months of August &amp; September 2012. Based on record review 2 of 11 individuals had Medication Administration Records, which contained missing medications entries and/or other errors: Individual #4 September 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:  - Trazadone 50 mg (1 time daily)  - Imipramine 50 mg (1 time daily) Individual #11 August 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:  - Pravastatin 80 mg (1 time daily)  - Oxcarbazepine 600 mg (2 times daily) September 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:  - Pravastatin 80 mg (1 time daily)  - Oxcarbazepine 600 mg (2 times daily)</td>
<td></td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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Survey Report #: Q.13.2.DDW.D4051.5.001.RTN.01.345
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(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.

(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;
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
(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 administrating the medication, signs and symptoms of adverse events and interactions with other medications;

NMAC 16.19.11.8 MINIMUM STANDARDS:
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual

D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.
Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:
- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.
<table>
<thead>
<tr>
<th>Tag # 1A15.2 &amp; 5I09 - Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 11 individuals</td>
</tr>
<tr>
<td>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
<td>The following were not found, incomplete and/or not current:</td>
</tr>
<tr>
<td>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual’s Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these</td>
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</table>

Provider:

State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

Provider:

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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. (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. (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). (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 subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data.
for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(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.
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
(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.
(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.

(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):
(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 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.

(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.

(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.

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

(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.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

(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.

(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation
(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.
(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.


CHAPTER 5  IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS
B. IDT Coordination
(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
(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.

**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 # 1A27 Incident Mgt Late & Failure to Report

#### 7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:

**A. Duty To Report:**

(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.

(2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:

(a) an environmental hazardous condition, which creates an immediate threat to life or health; or

(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.

(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.

**B. Notification: (1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
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</table>
| Based on the Incident Management Bureau’s Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 12 individuals. Individual #12  
- Incident date 2/18/2012. Allegation was Neglect. Incident report was received 2/23/2012. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was “Confirmed.” |

**Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.
<table>
<thead>
<tr>
<th>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: 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.</td>
<td>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 4 of 11 individuals. 1. Parent/Guardian Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers’ Property) (#1, 6, 10 &amp; 11)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>E. Consumer and Guardian Orientation Packet: 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.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>Tag # 1A29 Complaints / Grievances - Acknowledgement</td>
<td>Standard Level Deficiency</td>
<td>Provider</td>
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<tr>
<td>------------------------------------------------------</td>
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<tr>
<td><strong>NMAC 7.26.3.6</strong>&lt;br&gt;A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</td>
<td>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 2 of 11 individuals.&lt;br&gt;• Grievance/Complaint Procedure Acknowledgement (#6 &amp; 10)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>NMAC 7.26.3.13 Client Complaint Procedure Available.</strong> A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client’s rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client’s rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td></td>
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</tr>
<tr>
<td><strong>NMAC 7.26.4.13 Complaint Process:</strong>&lt;br&gt;A. (2). The service provider’s complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider’s complaint or grievance procedure</td>
<td></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

Provider:

Grievance/Complaint Procedure Acknowledgement (#6 & 10)
<table>
<thead>
<tr>
<th>Tag # 1A31 Client Rights/Human Rights</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:</strong></td>
<td>Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 11 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>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].</td>
<td>A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions.</td>
<td></td>
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<tr>
<td>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.</td>
<td>No documentation was found regarding Human Rights Approval for the following: • Physical Restraint (Door Alarm) - (Individual #6)</td>
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<tr>
<td>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]</td>
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</tbody>
</table>

**Long Term Services Division**  
**Policy Title: Human Rights Committee**

Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
Requirements Eff Date: March 1, 2003

IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least
five years from the completion of each individual’s Individual Service Plan.

**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:**

**Medication Assessment and Delivery**

**Procedure Eff Date:** November 1, 2006

B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency’s Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Tag # 1A33.1 Board of Pharmacy - Lic</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual 6. Display of License and Inspection Reports A. The following are required to be publicly displayed: □ Current Custodial Drug Permit from the NM Board of Pharmacy □ Current registration from the consultant pharmacist □ Current NM Board of Pharmacy Inspection Report</td>
<td>Based on observation, the Agency failed to provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 2 of 4 residences: Individual Residence: • Current Custodial Drug Permit from the NM Board of Pharmacy (#1 &amp; 11) Note: Individual #1 shares a residence with individuals who were not on the sample &amp; Individual #11 shares a residence with individuals who were not on the sample.</td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>Tag # 6L13 Community Living Healthcare Reqts.</td>
<td>Standard Level Deficiency</td>
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<td>---------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>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 2 of 7 individuals receiving Community Living Services. The following was not found, incomplete and/or not current:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>Blood Levels</strong></td>
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<tr>
<td>° Individual #5 - As indicated by collateral documentation reviewed, lab work was ordered on 11/14/2011. No evidence of lab results were found.</td>
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<tr>
<td><strong>Review of Psychotropic Medication</strong></td>
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</tr>
<tr>
<td>° Individual #5 - According to ISP Individual #5 is to have a medication review every, 6-months. No evidence was found for the following time frame to indicate they were completed (5/2012 – 10/2012).</td>
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</tr>
<tr>
<td><strong>Abnormal Involuntary Movement Screening and Tardive Dyskinesia Screenings</strong></td>
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<tr>
<td>° None found 10/2011 – 10/2012 for Risperidone (#4)</td>
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</tr>
<tr>
<td>° None found 10/2011 – 10/2012 for Risperdal (#5)</td>
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</tbody>
</table>
detailed in Chapter One section III E:
Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

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.

(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.

(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.

(5) That the physical property and grounds are free of hazards to the individual's health and safety.

(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:

(a) The individual has a primary licensed physician;

(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;

(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;

(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and

(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in


Survey Report #: Q.13.2.DDW.D4051.5.001.RTN.01.345
medication or daily routine).

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)


**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**

**L. Residence Requirements for Family Living Services and Supported Living Services**

(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:

- Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;
- General-purpose first aid kit;
- When applicable due to an individual’s health status, a blood borne pathogens kit;
- Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;
- Accessible telephone numbers of poison control centers located within the line of sight of the telephone;
- 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;
- 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
- Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 7 & 11)

*Note: Individuals # 5 & 7 share a residence.*

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on observation, the Agency failed to ensure that each individual’s residence met all requirements within the standard for 2 of 4 Supported Living residences.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>The following items were not found, not functioning or incomplete:</td>
<td></td>
</tr>
<tr>
<td><strong>Supported Living Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td>• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#5 &amp; 7)</td>
<td></td>
</tr>
<tr>
<td>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 7 &amp; 11)</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
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

<table>
<thead>
<tr>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability</strong> — State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</td>
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<td></td>
</tr>
</tbody>
</table>

#### Tag # 5125 Supported Employment Reimbursement

**Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**

**CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**

**A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.

**B. Billable Units:** 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:

1. Date, start and end time of each service encounter or other billable service interval;
2. A description of what occurred during the encounter or service interval; and
3. The signature or authenticated name of staff providing the service.

**MAD-MR: 03-59 Eff 1/1/2004**

**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 2 of 9 individuals.

#### Individual #2

- **July 2012**
  - The Agency billed 45.25 hours of Supported Employment (T2013 U3) on 7/31/2012. Documentation received accounted for 39 hours.

- **August 2012**
  - The Agency billed 58.25 hours of Supported Employment (T2013 U3) on 8/31/2012. Documentation received accounted for 55 hours.

- **September 2012**
  - The Agency billed 54.25 hours of Supported Employment (T2013 U3) on 9/30/2012. Documentation received accounted for 22 hours.

#### Individual #7

- **July 2012**
  - The Agency billed 62.50 hours of Supported Employment (T2013 U3) on 7/31/2012. Documentation received accounted for 23 hours.

- **August 2012**
  - The Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 2 of 9 individuals.

#### Provider:

- State your Plan of Correction for the deficiencies cited in this tag here:

#### Provider:

- Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:
to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS

E. Reimbursement

(1) Billable Unit:

(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.

(b) The billable unit for Individual Supported Employment is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less then one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:

   (i) Researching potential employers via telephone, Internet, or visits;
   (ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;
   (iii) Arranging appointments for job tours,

   • The Agency billed 33.50 hours of Supported Employment (T2013 U3) on 8/31/2012. Documentation received accounted for 28 hours.

Note: Agency maintains daily documentation for hours billed, nevertheless total hours are billed as one increment on the last day of the month.
interviews, and job trials;
(iv) Documenting job search and acquisition progress;
(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual’s progress, needs and satisfaction; and
(vi) Meetings with individual surrounding job development or retention not at the employer’s site.
(c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.

(d) Group Supported Employment is a fifteen-minute unit.

(e) Self-employment is a fifteen minute unit.

(4) Billable Activities include:

(a) Activities conducted within the scope of services;
(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and
(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.
<table>
<thead>
<tr>
<th>Tag # 5I44</th>
<th>Adult Habilitation Reimbursement</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 2 of 7 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>
| CHAPTER I III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION | Individual #2 September 2012  
- The Agency billed 73 units of Adult Habilitation (T2021 U4) from 9/17/2012 through 9/21/2012. Documentation received accounted for 72 units. | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |  |
| A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. | Individual #5 August 2012  
- The Agency billed 116 units of Adult Habilitation (T2021 U2) from 8/6/2012 through 8/12/2012. Documentation received accounted for 96 units. |  |  |
| B. Billable Units: 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: |  |  |  |
| (1) Date, start and end time of each service encounter or other billable service interval;  
(2) A description of what occurred during the encounter or service interval; and  
(3) The signature or authenticated name of staff providing the service. |  |  |  |
| MAD-MR: 03-59 Eff 1/1/2004  
8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to |  |  |  |

CHAPTER 5 XVI. REIMBURSEMENT

A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual’s level of care.

B. Billable Activities
(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non-face-to-face under the following conditions: (a) Time that is non-face-to-face is documented separately and clearly identified as to the nature of the activity; and (b) Non-face-to-face hours do not exceed 5% of the monthly billable hours.

(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours.
Date: February 22, 2013

To: Susan Karcz, Director
Provider: A Better Way of Living, Inc.
Address: 202 Central SE Suite 200
State/Zip: Albuquerque, New Mexico 87102
E-mail Address: susank@abetterwaynm.org
Region: Metro
Survey Date: November 13 – 16, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation & Supported Employment)
Survey Type: Routine

Dear Ms. Karcz,

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