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:

**Partial Compliance with Conditions of Participation**

This determination is based on non compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings 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 505-231-7436 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,

*Erica Nilsen, BA*

Erica Nilsen, BA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: November 12, 2013

Present:

**A Better Way of Living, Inc.**
Susan Karcz, Executive Director

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor
Meg Pell, BA, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Exit Conference Date: November 14, 2013

Present:

**A Better Way of Living, Inc.**
Susan Karcz, Executive Director
Christina Gonzales, Program Support Specialist
Chris Johnson, Residential Program Director
Sabrina Smith, Administrative Director
Mark Rosebrough, Supported Employment Director
Tom Reyes, Independent Living Director

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Meg Pell, BA, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 14
3 - Jackson Class Members
11 - Non-Jackson Class Members
6 - Supported Living
3 - Independent Living
4 - Adult Habilitation
6 - Supported Employment

Total Homes Visited
Number: 6

Supported Living Homes Visited
Number: 6

Persons Served Records Reviewed
Number: 14

Persons Served Interviewed
Number: 8
Persons Served Observed Number: 6 (Six Individuals were not available during the on-site survey as they were involved in other activities which surveyors did not want to disrupt).

Direct Support Personnel Interviewed Number: 15

Service Coordinator Personnel Interviewed Number: 2

Direct Support Personnel Records Reviewed Number: 73

Service Coordinator Records Reviewed Number: 6

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
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 deficiencies and non-compliance.

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-231-7436 or email at Anthony.Fragua@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD 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 six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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 Plan of Correction:
- 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, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans 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 indicators; 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 POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
   a. Electronically at Anthony.Fragua@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” 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.
e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

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. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI), the preferred method is that you submit your documents 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. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
   a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
   b. Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC. to correct all unjustified units identified and submitted for payment 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 provider compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level...
deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

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

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

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

### Conditions of Participation (CoPs)

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

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

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

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

#### Service Domain: Level of Care

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

#### Service Domain: Plan of Care

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

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

<table>
<thead>
<tr>
<th>Condition of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. <strong>Qualified Providers</strong>: Agencies shall ensure support staff has completed criminal background screening and all mandated trainings as required by the DDSD.</td>
</tr>
</tbody>
</table>

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

#### Service Domain: Plan of Care

<table>
<thead>
<tr>
<th>Condition of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. <strong>ISP Implementation</strong>: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.</td>
</tr>
</tbody>
</table>

#### Service Domain: Health, Welfare and Safety

<table>
<thead>
<tr>
<th>Condition of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <strong>Individual Health, Safety and Welfare</strong> <em>(Safety)</em>: Individuals have the right to live and work in a safe environment.</td>
</tr>
<tr>
<td>7. <strong>Individual Health, Safety and Welfare (Healthcare Oversight)</strong>: 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.</td>
</tr>
</tbody>
</table>

### QMB Determinations of Compliance

#### Compliance with Conditions of Participation

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

#### Partial-Compliance with Conditions of Participation

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

Providers receiving a repeat determination of Partial-Compliance for repeat deficiencies at the level of a Condition in any Service Domain may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.
Non-Compliance with Conditions of Participation
The QMB determination of Non-Compliance with Conditions of Participation indicates a provider is significantly out of compliance with Conditions of Participation in multiple Service Domains. The agency may have one or more Condition level tags in each of 3 relevant Service Domains. This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

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

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

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

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

The following limitations apply to the IRF process:
- The written request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.

• Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not received within 10 business days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

The IRF Committee will review the request, the Provider will be notified in writing of the ruling; no face-to-face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
## Service Domain: Service Plans: ISP Implementation

Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.

<table>
<thead>
<tr>
<th>Tag # 1A08</th>
<th>Agency Case File</th>
</tr>
</thead>
</table>

**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 individual’s address, telephone number,

2. Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 4 of 14 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:
   - Documentation of Guardianship/Power of Attorney (#13)
   - Annual Physical (#10)
   - Dental Exam
     - Individual #11 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
   - Vision Exam
     - Individual #8 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
   - Auditory Exam
     - Individual #11 - As indicated by collateral

**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>
<thead>
<tr>
<th>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;</th>
</tr>
</thead>
<tbody>
<tr>
<td>The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</td>
</tr>
<tr>
<td>Progress notes and other service delivery documentation;</td>
</tr>
<tr>
<td>Crisis Prevention/Intervention Plans, if there are any for the individual;</td>
</tr>
<tr>
<td>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;</td>
</tr>
<tr>
<td>When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</td>
</tr>
<tr>
<td>Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</td>
</tr>
<tr>
<td>The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</td>
</tr>
<tr>
<td>Complete file for the past 12 months;</td>
</tr>
<tr>
<td>ISP and quarterly reports from the current and prior ISP year;</td>
</tr>
<tr>
<td>Intake information from original admission to services; and</td>
</tr>
<tr>
<td>When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</td>
</tr>
</tbody>
</table>

Documentation reviewed, exam was completed on 6/08/2011. Follow-up was to be completed in 2 years. No evidence of follow-up found.
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 # 1A32 and 6L14</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Service Plan Implementation</td>
<td>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 14 individuals.</td>
<td></td>
</tr>
<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Administrative Files Reviewed:</strong></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td><strong>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No Outcomes or DDSD exemption/decision justification found for Supported Employment Services. As indicated by NMAC 7.26.5.14 &quot;Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #7</td>
<td></td>
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<tr>
<td></td>
<td>• Review of Agency’s documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Work/Learn.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• None found regarding: “Will assist 1 customer per week with finding an item in his department” for 7/2013 - 9/2013.</td>
<td></td>
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<tr>
<td></td>
<td>Individual #11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• None found for 8/2013 - 9/2013.</td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.14.2.DDW.D4051.5.001.RTN.01.028

Page 15 of 75
play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.
[05/03/94; 01/15/97; Recompiled 10/31/01]

| Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: |
| Individual #13 |
| • None found for 11/1 - 13, 2013. |
### Tag # 6L14
Residential Case File

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 6 Individuals receiving Supported Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td>- Annual ISP (#14)</td>
<td></td>
</tr>
<tr>
<td>- ISP Signature Page (#14)</td>
<td></td>
</tr>
<tr>
<td>- Addendum A (#14)</td>
<td></td>
</tr>
<tr>
<td>- Individual Specific Training Section of ISP (formerly Addendum B) (#14)</td>
<td></td>
</tr>
<tr>
<td>- Medical Emergency Response Plans</td>
<td></td>
</tr>
<tr>
<td>- Pain (#12)</td>
<td></td>
</tr>
</tbody>
</table>

#### V. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS

**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 implementation
6. Progress notes written by direct care staff

Rungs on the Ladder of Learning (RLL) - Reflective Practice (RP) - 2013
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.
### Service Domain: Qualified Providers – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

<table>
<thead>
<tr>
<th>Tag # 1A11.1</th>
<th>Transportation Training</th>
</tr>
</thead>
</table>
| **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...  

Based on record review, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 5 of 73 Direct Support Personnel.

**No documented evidence was found of the following required training:**

- Transportation (DSP #70, 83, 85, 86, 103)

**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: →
- 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)
- Operating wheelchair lifts (if applicable to the staff's role)
- Wheelchair tie-down procedures (if applicable to the staff's role)
- Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
</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 did not ensure Orientation and Training requirements were met for 3 of 73 Direct Support Personnel.  
Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:  
- Pre- Service (DSP #70)  
- Rights and Advocacy (DSP #81, 100)  
- Positive Behavior Supports Strategies (DSP #81) | 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>
<thead>
<tr>
<th>Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for 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>
</tbody>
</table>
H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.

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.
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Personnel Competency</td>
<td>Based on interview, the Agency did not ensure training competencies were met for 4 of 15 Direct Support Personnel.</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>
</tr>
<tr>
<td>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</td>
<td></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>
<td></td>
</tr>
<tr>
<td>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</td>
<td></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 individual;</td>
<td></td>
</tr>
<tr>
<td>Based on interview, the Agency did not ensure training competencies were met for 4 of 15 Direct Support Personnel.</td>
<td></td>
</tr>
<tr>
<td>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
</tr>
<tr>
<td>- DSP #98 stated, “No, he does not have a behavior crisis plan.” According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #12)</td>
<td></td>
</tr>
<tr>
<td>When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
</tr>
<tr>
<td>- DSP #96 stated, “No.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #14)</td>
<td></td>
</tr>
<tr>
<td>When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
</tr>
<tr>
<td>- DSP #47 stated, “Plan is not in the book. I wasn’t trained on PT. I don’t know why he has PT.” According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #11)</td>
<td></td>
</tr>
<tr>
<td>When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:</td>
<td></td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</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

- DSP #40 stated, “Notify RN most of the time before but sometimes we will give it without calling the RN, like pepto bismol. Sometimes they want it so much it would prevent us from doing our job if we had to call RN.” According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP.

(Individual #13)
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.
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>
| **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.  
**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.  
**Policy Title:** Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2014. | Based on record review, the Agency did not ensure Incident Management Training for 2 of 79 Agency Personnel.  
**Direct Support Personnel (DSP):**  
- Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (DSP#70, 103) | **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: → |
II. POLICY STATEMENTS:

A. Individuals shall receive services from 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 # 1A36</th>
<th>Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<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>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Orientation and Training Requirements</strong>: 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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NMAC 7.26.5.7 “service coordinator”:</strong> the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 4 of 6 Service Coordinators.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Person Centered Planning (2-Day) (SC #113, 116, 117)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Promoting Effective Teamwork (SC #113, 115, 116)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advocacy Strategies (SC #117)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sexuality for People with Developmental Disabilities (SC #113, 117)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider</strong>: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider</strong>: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and monitors the service plan within the community service provider agency

**NMAC 7.26.5.11** (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual’s progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more “key” community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

1. The designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
2. The designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
3. The designated service coordinator shall be familiar with and understand community service delivery and supports;
4. The designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the
individual being served;
<table>
<thead>
<tr>
<th>Tag # 1A37</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Specific Training</td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 1 of 79 Agency Personnel.</td>
</tr>
<tr>
<td></td>
<td>Review of personnel records found no evidence of the following:</td>
</tr>
<tr>
<td></td>
<td>Direct Support Personnel (DSP):</td>
</tr>
<tr>
<td></td>
<td>- Individual Specific Training (DSP #86)</td>
</tr>
</tbody>
</table>

**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. **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.

**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 training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.

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: →
(formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
**Service Domain: Health and Welfare** – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency had not fully implemented their Continuous Quality Management System as required by standard.</td>
</tr>
<tr>
<td></td>
<td>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health</td>
<td></td>
</tr>
</tbody>
</table>

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;
(6) Quality and completeness documentation; and
(7) Trends in individual and guardian satisfaction.

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

(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
(4) community based service providers
<p>| providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues. |       |       |</p>
<table>
<thead>
<tr>
<th>Tag # 1A09</th>
<th>Medication Delivery Routine Medication Administration</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of August, September and November 2013. Based on record review, 6 of 14 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 August 2013 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications: • Cerovite Multivitamin (1 time daily) • Acidophilus (3 times daily) • Melatonin 3mg (1 time daily) • Tea Tree Oil (1 time daily) • Flunisolide Nasal Spray (2 times daily) September 2013 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications: • Cerovite Multivitamin (1 time daily) • Acidophilus (3 times daily)</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>

E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;
(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
(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 administering 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

- Melatonin 3mg (1 time daily)
- Tea Tree Oil (1 time daily)
- Flunisolide Nasal Spray (2 times daily)

Individual #3
August 2013
As indicated by the Medication Administration Records the individual is to take Cerovite Multivitamin tablets by mouth (1 time daily). According to the Physician's Orders, Cerovite Multivitamin liquid (15ml) is to be taken via G-Tube 1 time daily. Medication Administration Record and Physician's Orders do not match.

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Lamotrigine 200mg (2 times daily) – Blank 8/31 (8PM)
- Copaxone 20mg (1 time daily) – Blank 8/31 (4PM)
- Baclofen 10mg (3 times daily) – Blank 8/9 (2PM)
- Glucerna 4oz (4 times daily) – Blank 8/12 (2PM); 9/25 (9PM)
- Seroquel 200mg (1 time daily) – Blank 8/31 (8PM)

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:
- Aspirin EC 81mg (1 time daily)
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.

- Acetaminophen 325mg (1 time daily)
- Benefiber for Children (Wheat De) 3.5gms (2 times daily)
- Cephalexin 500mg (4 times daily)
- Ferrous Silfate 220mg.ml (2 times daily)

September 2013

As indicated by the Medication Administration Records the individual is to take Cerovite Multivitamin tablets by mouth (1 time daily). According to the Physician’s Orders, Cerovite Multivitamin liquid (15ml) is to be taken via G-Tube 1 time daily. Medication Administration Record and Physician’s Orders do not match.

Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:

- Aspirin EC 81mg (1 time daily)
- Acetaminophen 325mg (1 time daily)
- Benefiber for Children (Wheat De) 3.5gms (2 times daily)
- Ferrous Silfate 220mg.ml (2 times daily)

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

- Acidophilus (3 times daily) – Blank 9/7 (2PM and 8PM)
- Aloe Vesta Ointment (2-3 times daily) – Blank 9/7 (8PM)
- Calcium Carbonate (2 times daily) – Blank
9/7 (8PM)
- Fish Oil 1000mg (2 times daily) – Blank 9/7 (8PM)
- Seroquel 200mg (1 time daily) – Blank 9/7 (8PM)

Medication Administration Records did not contain the route of administration for the following medications:
- Vitamin E 400 units (1 time daily)

Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:
- Vitamin E 400 units (1 time daily)

Individual #9
August 2013
As indicated by the Medication Administration Records the individual is to take Levothyroxin 0.1mg (1 time daily). According to the Physician’s Orders, Levothyroxin 1mcg is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match.

As indicated by the Medication Administration Records the individual is to take Omeprazole 20mg (1 time daily). According to the Physician’s Orders, Omeprazole 20mg is to be taken 2 times daily. Medication Administration Record and Physician’s Orders do not match.

September 2013
As indicated by the Medication Administration Records the individual is to take Levothyroxin 0.1mg (1 time daily). According to the
<table>
<thead>
<tr>
<th>Physician's Orders, Levothyroxin 1mcg is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match.</th>
</tr>
</thead>
<tbody>
<tr>
<td>As indicated by the Medication Administration Records the individual is to take Omeprazole 20mg (1 time daily). According to the Physician’s Orders, Omeprazole 20mg is to be taken 2 times daily. Medication Administration Record and Physician’s Orders do not match.</td>
</tr>
</tbody>
</table>
| Individual #12  
August 2013  
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:  
• Oxcarbazepine 600mg (2 times daily) – Blank 8/31 (8PM) |
| Individual #13  
August 2013  
As indicated by the Medication Administration Records the individual is to take 2 tablets of Hydroxyzine 25 mg (1 time daily). According to the Physician’s Orders, 1 tablet of Hydroxyzine 25 mg is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match. |
| September 2013  
As indicated by the Medication Administration Records the individual is to take 2 tablets of Hydroxyzine 25 mg (1 time daily). According to the Physician’s Orders, 1 tablet of Hydroxyzine 25 mg is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match. |
| Individual #14 |
August 2013
As indicated by the Medication Administration Records the individual is to take ½ a tablet of Abilify 30 mg (1 time daily). According to the Physician’s Orders, ½ tablet of Abilify 30 mg is to be taken 2 times daily. Medication Administration Record and Physician’s Orders do not match.

Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
• Lamictal 100mg (2 times daily)
• Cleocin Gel (2 times daily)
• Clindamycin 1% (2 times daily)
• Tenex 1mg (3 times daily)

Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:
• Anafranil (Clomipramine) 75mg (1 time daily)

September 2013
As indicated by the Medication Administration Records the individual is to take ½ a tablet of Abilify 30 mg (1 time daily). According to the Physician’s Orders, ½ tablet of Abilify 30 mg is to be taken 2 times daily. Medication Administration Record and Physician’s Orders do not match.

Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Lamictal 100mg (2 times daily)
- Cleocin Gel (2 times daily)
- Clindamycin 1% (2 times daily)
- Tenex 1mg (3 times daily)

Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:
- Anafranil (Clomipramine) 75mg (1 time daily)

November 2013
Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:
- Anafranil (Clomipramine) 75mg (1 time daily)
- Lithium Carbonate 300mg (3 times daily)
<table>
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<tr>
<th>Tag # 1A09.1</th>
<th>Standard Level Deficiency</th>
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</table>

**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.

**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;

(b) Prescribed dosage, frequency and method/route of administration, times

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<tr>
<td>Individual #1</td>
<td>August 2013</td>
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<td>Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
</tr>
<tr>
<td></td>
<td>• Dulcolax 10mg (PRN)</td>
</tr>
<tr>
<td></td>
<td>• Deraseptin (PRN)</td>
</tr>
<tr>
<td></td>
<td>• Acid Gone Susp. 15mls (PRN)</td>
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<tr>
<td>Individual #14</td>
<td>August 2013</td>
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<tr>
<td></td>
<td>Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
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<td></td>
<td>• Dulcolax 10mg (PRN)</td>
</tr>
<tr>
<td></td>
<td>• Deraseptin (PRN)</td>
</tr>
<tr>
<td></td>
<td>• Acid Gone Susp. 15mls (PRN)</td>
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<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
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<td></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>


Survey Report #: Q.14.2.DDW.D4051.5.001.RTN.01.028
and dates of administration;
(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 administering the medication, signs and symptoms of adverse events and interactions with other medications;

<table>
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<tr>
<th>Medications</th>
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<tbody>
<tr>
<td>Colace 100mg (PRN)</td>
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<tr>
<td>Proctocort 1%n (PRN)</td>
</tr>
</tbody>
</table>

September 2013
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:

<table>
<thead>
<tr>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colace 100mg (PRN)</td>
</tr>
<tr>
<td>Proctocort 1%n (PRN)</td>
</tr>
</tbody>
</table>

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.

Department of Health

Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006
F. PRN Medication

3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

H. Agency Nurse Monitoring

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual’s response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse’s assessment of the individual and consideration of the individual’s diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual’s condition and the skill level
and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual’s response to medication.

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

**Medication Assessment and Delivery Procedure Eff Date: November 1, 2006**

C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (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).

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting...
lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
### Tag # 1A27
Incident Mgt. Late and 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 instructions for the completion and filing are based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 1 of 16 individuals.

   **Individual #15**
   - Incident date 3/6/2013. Allegation was Emergency Services. Incident report was received 3/20/2013. Late Reporting. IMB issued a Late Reporting for Emergency Services.

**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.14.2.DDW.D4051.5.001.RTN.01.028

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 # 1A27.2</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty to Report</td>
<td></td>
</tr>
<tr>
<td>IRs Filed During On-Site and/or IRs Not Reported by Provider</td>
<td>Based on record review, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 16 Individuals.</td>
</tr>
</tbody>
</table>

**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.

Based on record review, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 16 Individuals.

During the on-site survey November 12 - 14, 2013, surveyors found evidence of 1 internal agency incident reports, which had not been reported to DHI and/or APS/CYFD, as required by regulation.

The following internal incidents were reported as a result of the on-site survey:

Individual #16
- Incident date 5/20/2013 (9AM). Type of incident identified was Law Enforcement Involvement. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 11/14/2013 by DHI/QMB.

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: →
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 instructions for the completion and filing are available at the division’s website; http://dhi.health.state.nm.us/elibrary/ironline/irhp or may be obtained from the department by calling the toll free number.

(2) Division Incident Report Form and Notification by Community Based Service Providers: The community based service provider shall report incidents utilizing the division’s incident report form consistent with the requirements of the division’s incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division’s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.
### Tag # 1A28.2  
Incident Mgt. System - Parent/Guardian Training

#### 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 require all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.

**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.

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 1 of 14 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
</tr>
<tr>
<td>• Parent/Guardian Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (#13)</td>
</tr>
</tbody>
</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: →
<table>
<thead>
<tr>
<th>Tag # 1A29</th>
<th>Complaints / Grievances Acknowledgement</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.26.3.6</td>
<td>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 did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 14 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here:</td>
</tr>
<tr>
<td>NMAC 7.26.3.13 Client Complaint Procedure Available. 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>• Grievance/Complaint Procedure Acknowledgement (#13)</td>
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</tr>
<tr>
<td>NMAC 7.26.4.13 Complaint Process: 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>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
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<tr>
<td>Tag # 1A31</td>
<td>Standard Level Deficiency</td>
<td>Provider:</td>
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<tr>
<td>Client Rights/Human Rights</td>
<td>Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 2 of 14 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:</td>
<td>A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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<tr>
<td></td>
<td>No documentation was found regarding Quarterly Human Rights Approval for the following:</td>
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<tr>
<td></td>
<td>• Physical Restraint per Positive Behavioral Crisis Plan- Last review date 6/2013. (Individual #9)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>• Physical Restraint (Handle With Care) per Positive Behavioral Crisis Plan- Last review date 3/2013. (Individual #13)</td>
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<tr>
<td></td>
<td>Long Term Services Division</td>
<td></td>
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<tr>
<td></td>
<td>Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 2 of 14 Individuals.</td>
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<td></td>
<td>Long Term Services Division</td>
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Policy Title: Human Rights Committee
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</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| Board of Pharmacy – Med. Storage | New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual  
E. Medication Storage:  
1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.  
2. Drugs to be taken by mouth will be separate from all other dosage forms.  
3. A locked compartment will be available in the refrigerator for those items labeled “Keep in Refrigerator.” The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.  
4. Separate compartments are required for each resident’s medication.  
5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.  
6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.  
8. References  
A. Adequate drug references shall be available for facility staff  
H. Controlled Substances (Perpetual Count Requirement)  
1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, | Based on record review and observation, the Agency did not to ensure proper storage of medication for 1 of 14 individuals.  
Observation included:  
Individual #13  
- Propranolol: expired 11/6/2013. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.  
- Sertraline HCL: expired 11/6/2013. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.  
- Hydroxyzine: expired 11/6/2013. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.  
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: → |
### Tag # 6L13
Community Living Healthcare Reqts.

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</td>
<td></td>
</tr>
<tr>
<td>G. Health Care Requirements for Community Living Services.</td>
<td></td>
</tr>
<tr>
<td>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual’s health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.</td>
<td></td>
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<tr>
<td>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual’s HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</td>
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<tr>
<td>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</td>
<td></td>
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<tr>
<td>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 9 individuals receiving Community Living Services.</td>
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<tr>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
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<tr>
<td>• <strong>Dental Exam</strong></td>
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<tr>
<td>◦ Individual #3 - As indicated by collateral documentation reviewed, the exam was completed on 3/11/2013. No evidence of exam results were found.</td>
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<tr>
<td>◦ Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</td>
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<tr>
<td>• <strong>Vision Exam</strong></td>
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<tr>
<td>◦ Individual #12 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
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<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</tbody>
</table>

(a) Provision of health care oversight consistent with these Standards as 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 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.
<table>
<thead>
<tr>
<th>Tag # 6L25</th>
<th>Residential Health and Safety (SL/FL)</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 observation, the Agency did not ensure that each individual’s residence met all requirements within the standard for 2 of 6 Supported Living. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td><strong>Supported Living Requirements:</strong></td>
<td><strong>Provider:</strong></td>
<td></td>
</tr>
<tr>
<td>L. Residence Requirements for Family Living Services and Supported Living Services</td>
<td>- 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 (#12, 13)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
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<tr>
<td>(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:</td>
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<tr>
<td>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</td>
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<td>(b) General-purpose first aid kit;</td>
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<td>(c) When applicable due to an individual’s health status, a blood borne pathogens kit;</td>
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<td>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</td>
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<td>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</td>
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<tr>
<td>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</td>
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<tr>
<td>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and</td>
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<tr>
<td>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence</td>
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</tbody>
</table>
unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Domain: Medicaid Billing/Reimbursement</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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<tr>
<td><strong>Tag # 5125 Supported Employment Reimbursement</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 <strong>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</strong> <strong>A. General:</strong> 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. <strong>B. Billable Units:</strong> 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. <strong>MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</strong> Providers must maintain all records necessary</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 6 individuals</td>
<td></td>
<td></td>
</tr>
</tbody>
</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: →
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, 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 # 6L28</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Living Reimbursement</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Independent Living Services for 1 of 3 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td>Individual #6 July 2013 • The Agency billed 1 unit of Independent Living (T2030) from 7/1/2013 through 7/31/2013. Per Individual’s budget the individual is to receive Regular (no less than 20 hours). Documentation received accounted for 4.5 hours, which is less than the required amount.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

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 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 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES
D. Reimbursement for Independent Living Services: The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.
Dear Ms. Karcz;

Your request for a Reconsideration of Findings was received on February 12, 2014. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A37
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the original Training Document Request form kept by QMB surveyors, Individual Specific Training for Direct Support Personnel (DSP) #86 was requested at the time of survey and not provided prior to the end of survey. The Training Document Request form listing this item as missing was signed by Susan Karcz on 11/13/2013 and a final copy, still listing this item as missing, was provided to the agency on 11/14/2014 and was again signed by Susan Karcz.

Regarding Tag # 1A32 and 6L14
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Supported Living Data Collection/Tracking for Individual #13 would not have been requested on the Document Request Form provided for the agency files. This item was reviewed in the Individual’s Residential File at their home. Based on the Residential File Review Tool, Supported Living Data Collection/Tracking for Individual #13 for the time period of November 1-13, 2013 was listed as missing. Surveyors reviewed the tool with staff and the tool was signed by Mylan Phan on 11/13/2013. This serves as acknowledgment that missing items were requested but not provided prior to the end of the site visit. Supported Employment Data Collection/Tracking for Individual #11 will be removed. Supported Employment services were not billed in the months of August and September 2013. The remaining citations noted in this tag were not disputed.
Regarding Tag #1A09
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Modification, removal or upholding of Medication Administration Record (MAR) findings are as follows:

- Individual #3
  - Findings for August and September 2013 will be modified. Documentation of Physician’s Orders for Cephalexin and Ferrous Sulfate were provided; however, per the Physician’s Orders provided, the Physician’s Order and the MAR for Ferrous Sulfate do not match. According to the MAR, Ferrous Sulfate 220mg.ml is to be given 2 times daily. According to the Physician’s Orders provided, Ferrous Sulfate 325mg (of 300(60fe)mg/5ml) 5.5ml is to be given twice daily.

- Individual #9
  - Findings in regards to Physician’s Orders and Medication Administration Records (MAR) not matching will be removed for the months of August and September 2013.

- Individual #13
  - Findings in regards to Physician’s Orders and Medication Administration Records (MAR) not matching will be removed for the months of August and September 2013.

- Individual #14
  - Medication Administration findings will be modified. Medication Administration Records (MAR) verifying Anafanil was correctly documented were only provided for August and September 2013. The citation for November 2013 will remain as no evidence medication was correctly documented during this month was provided.

The remaining citations noted in this tag were not disputed.

Regarding Tag #5I25
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. The modifications and removal of billing deficiencies are as follows:

- Individual #12
  - Billing deficiency for July 2013 and September 2013 will be modified.
    - July 2013
      - The Agency billed 20.5 units of Supported Employment (T2013 U3) on 07/31/2013. Documentation provided accounts for 19.5 units.
    - September 2013
      - The Agency billed 62.75 units of Supported Employment (T2013 U3) on 09/30/2013. Documentation provided accounts for 61.75 units.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.
Thank you.
Respectfully,

Crystal Lopez-Beck
Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.14.2/DDW.D4051.5.001.RTN.12.072
Date: April 15, 2014

To: Susan Karcz, Executive Director
Provider: A Better Way of Living, Inc.
Address: 202 Central SE, Suite 200
State/Zip: Albuquerque, NM 87109
E-mail Address: susank@abetterwaynm.org
Region: Metro
Survey Date: November 12 - 14, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Independent Living) and 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 these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

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

Sincerely,

Tony Fragua
Tony Fragua
Plan of Correction Coordinator
Quality Management Bureau/DHI