Dear Ms. Lozano,

The Division of Health Improvement/Quality Management Bureau has completed a Focused Survey requested by the Internal Review Committee 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. The specific focus of the survey was to determine compliance with Individual health and safety and implementation of corrective actions needed which were identified by the DDSD following the concerns with the Immediate Safety Assessment done by DDSD on January 14, 2013:

a) Health and Safety of Individuals receiving services - **QMB Findings:** During the Focused Survey the QMB conducted an Agency administrative review as well as a review in the residence of each Individual served by the agency to follow up on concerns reported by DDSD; to determine if the agency has implemented corrective actions since the time of the Immediate Safety Assessment. Based on the findings of the Focused Survey, the Agency was able to correct all potential deficiencies and no concerns or deficiencies were identified in this area.

b) Access to Individuals and their residences - **QMB Findings:** During the Focused Survey the QMB conducted an Agency administrative review as well as a review in the residence of each Individual served by the agency to follow up on concerns reported by DDSD; to determine if the agency has implemented corrective actions since the time of the Immediate Safety Assessment. Based on the findings of the Focused Survey, the Agency was able to correct all potential deficiencies and no concerns or deficiencies were identified in this area.
c) Staff Competency regarding Health Care Plans, Medical Emergency Response Plans, therapy plans and the Incident Management System - QMB Findings: Deficiencies were identified in this area at a Condition of Participation Level; please see the attached Report of Findings for further information.

d) Healthcare Oversight/Medical follow-up - QMB Findings: Deficiencies were identified in this area at a Standard Level; please see the attached Report of Findings for further information.

e) Nursing Services; Nursing Availability - QMB Findings: During the Focused Survey the QMB conducted an Agency administrative review as well as a review in the residence of each Individual served by the agency to follow up on concerns reported by DDSD; to determine if the agency has implemented corrective actions since the time of the Immediate Safety Assessment. Based on the findings of the Focused Survey, the Agency was able to correct all potential deficiencies and no concerns or deficiencies were identified in this area.

f) Agency’s Incident Management System and process. - QMB Findings: Deficiencies were identified in this area at a Standard Level; please see the attached Report of Findings for further information.

After closely reviewing each of these areas the following Report of Findings will identify for you and your Agency each area in which there were deficiencies. This Report of Findings will be shared with the Developmental Disabilities Supports Division and the Internal Review Committee 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 your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

**Plan of Correction:**
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

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

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

1. Quality Management Bureau, Attention: Plan of Correction Coordinator  
   5301 Central Ave. NE Suite 400 Albuquerque, NM 87108

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

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.
Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

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

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

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

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

Please call the Plan of Correction Coordinator at 505-699-9356 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

_Amanda Castañeda, MPA_

Amanda Castañeda, MPA  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: February 13, 2013

Present:

**Casa Alegre**
Linda Lozano, Incident Management Coordinator/Service Coordinator/Administrator
Vicky Lozano, Owner/Administrator/Incident Management Coordinator/Service Coordinator/Administrator

**DOH/DHI/QMB**
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor

Preliminary Exit Conference Date: February 14, 2013

Present:

**Casa Alegre**
Linda Lozano, Assistant Administrator
Vicky Lozano, Owner/Administrator/Incident Management Coordinator/Service Coordinator/Administrator

**DOH/DHI/QMB**
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor

**DDSD - Southeast Regional Office**
Michelle Lyon, DDSD, SERO Regional Director
Marie Sanders, RN, DDSD, SERO
Brianna Massey, DDSD, SERO

Exit Conference Date: March 5, 2013

Present:

**Casa Alegre**
Linda Lozano, Assistant Administrator
Vicky Lozano, Owner/Administrator/Incident Management Coordinator/Service Coordinator/Administrator

**DOH/DHI/QMB**
Cynthia Nielsen, MSN, RN, Healthcare Surveyor

**DDSD - Southeast Regional Office**
Marie Sanders, RN, DDSD, SERO

Administrative Locations Visited Number: 1
Total Sample Size Number: 11
2 - *Jackson* Class Members
9 - *Non-Jackson* Class Members
9 - Supported Living
10 - Adult Habilitation
2 - Supported Employment
Total Homes Visited Number: 3
   - Supported Living Homes Visited Number: 3

Persons Served Records Reviewed Number: 11 (A record review was complete for Individual #1, who was deceased at the time of the survey).

Persons Served Interviewed Number: 10

Persons Served Observed Number: 10

Direct Support Personnel Interviewed Number: 5

Direct Support Personnel Records Reviewed Number: 19

Service Coordinator Records Reviewed Number: 1

Administrative Processes and Records Reviewed:

- 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 and External Incident Management Reports and System Process
- Personnel Files, including nursing and subcontracted staff
- Agency On-Call System, Policy/Procedure and Process
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- General Events Reporting (Therap ®)
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Nursing Review/Interview
- Quality Assurance / Improvement Plan

CC: Distribution List:

DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
DOH – Internal Review Committee
Provider Instructions for Completing the QMB Plan of Correction (POC) Process

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

The Plan of Correction must address the required six CMS core elements to address each deficiency of the POC:
1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

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

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

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

Initial Submission of the Plan of Correction Requirements
1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
   a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108

Survey Report #: Q.13.3.DDW.D0161.4.001.FCD.01.067
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.

6. QMB will notify you when your POC has been “approve” or “denied.”
   a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

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

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.
The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency’s operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

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

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

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

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

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

**Conditions of Participation (CoPs)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The following limitations apply to the IRF process:
- The 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.
### Standard of Care

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

**CHAPTER 6. VIII. 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

**CMS Assurance – 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 # 6L14</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Case File</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 11 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
</tbody>
</table>
| | - Positive Behavioral Crisis Plan (#11)  
- Progress Notes written by DSP and/or Nurses regarding Health Status:  
  - Individual #5 - None found for February 11, 2013. |

**Provider:**

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

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
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 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
(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.
**CMS Assurance – Qualified Providers** – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

Tag # 1A22  
**Agency Personnel Competency**

**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.  
**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:  
(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;  
(2) Direct service personnel shall have the ability to read and carry out the requirements in an

<table>
<thead>
<tr>
<th>Condition of Participation Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| After an analysis of the evidence it has been determined the following finding resulted in a negative outcome and/or there is a significant potential for a negative outcome to occur.  
Based on interview, the Agency did not ensure training competencies were met for 2 of 5 Direct Support Personnel.  
**Note:** The 2 Direct Service Personnel interviewed worked with a total of 6 Individuals (three in each home). Additionally, DSP #47 was also providing Adult Habilitation service with 2 other DSP who were observed working with Individuals in the Adult Habilitation setting. During this time 3 DSP were observed working with the total sample (8 Individuals).  
**When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:**  
- DSP #47 stated, “I don’t think he has one.” According to the Individual Specific Training Section of the ISP, the individual has a Positive Behavioral Crisis Plan. (Individual #11)  
**When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s)  
**Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: →  
**Provider:**  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →  

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Survey Report #: Q.13.3.DDW.D0161.4.001.FCD.01.067
ISP;

(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;

(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

<table>
<thead>
<tr>
<th>covered, the following was reported:</th>
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<tbody>
<tr>
<td>• DSP #55 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Seizures. (Individual #2)</td>
<td></td>
</tr>
<tr>
<td>• DSP #55 stated, “No, not really, he doesn't.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Weight/Body Mass Index. (Individual #5)</td>
<td></td>
</tr>
<tr>
<td>• DSP #55 stated, “I don’t think he does.” As indicated by the Individual Specific Training section of the ISP, the Individual requires Health Care Plans. Within the contents of the ISP the Individual it specifically states the Individual requires a Health Care Plan for Heart Maintenance/Congestive Heart Failure. (Individual #7)</td>
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</tbody>
</table>

When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:

<table>
<thead>
<tr>
<th>covered, the following was reported:</th>
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</thead>
<tbody>
<tr>
<td>• DSP #55 stated, “I don't think he does.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Seizures. (Individual #2)</td>
<td></td>
</tr>
<tr>
<td>• DSP #55 stated, “Not that I know of.” As indicated by the Individual Specific Training section of the ISP, as well as in the body of the ISP, the Individual requires a Medical Emergency Response Plan for Heart Maintenance/Congestive Heart Failure. (Individual #7)</td>
<td></td>
</tr>
</tbody>
</table>
alternative tracking number; and
(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

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.

When DSP were asked if the Individual had a Seizure Disorder, the following was reported:

- DSP #55 was aware of the seizure disorder, stating, “Yes, grand mal and petite.” However, when asked by Surveyors if the Individual had an Individual-specific Medical Emergency Response Plan for Seizures, DSP #55 stated, “No.” Per Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Seizures. (Individual #2)

When DSP were asked what the individual's Diagnosis were, the following was reported:

- DSP #55 stated, “He doesn't have any really.” According to the individual’s ISP, the Individual is diagnosed with Hypothyroidism, Depression and Pancytopenia. Staff did not discuss the listed diagnosis. (Individual #5)
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td>Based on interview, the Agency did not provide documentation verifying completion of Incident Management Training for 1 of 19 Agency Personnel.</td>
</tr>
<tr>
<td>When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:</td>
<td></td>
</tr>
<tr>
<td>1. DSP #55 referred to reporting poster and stated, (I would) “call number, assume they would get back with me. I don’t know about the paperwork.” Staff was not able to identify either State Agency as which reporting is required for suspected abuse, neglect or exploitation.</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: →

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.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
**Tag # 1A43 General Events Reporting**

<table>
<thead>
<tr>
<th>Tag # 1A43 General Events Reporting</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy: General Events Reporting Effective 1/1/2012</td>
<td>Based on record review and interview the Agency failed to follow the General Events Reporting requirements as indicated by the policy as required by standard for 2 of 11 individuals.</td>
</tr>
<tr>
<td>1. Purpose</td>
<td>Agency record review of Seizure Activity Chart revealed the following occurrences were not entered into the General Events Reporting as required:</td>
</tr>
<tr>
<td>To report, track and analyze significant events experiences by adult participants of the DD Waiver program, which do not meet criteria for abuse, neglect or exploitation, or other “reportable incident” as defined by the Incident Management Bureau of the Division of Health Improvement, Department of Health, but which pose a risk to individuals served. Analysis of reported significant events is intended to identify emerging patterns so that preventative actions can be identified at the individual, provider agency, regional and statewide levels.</td>
<td>Individual #2</td>
</tr>
<tr>
<td>II. Policy Statements</td>
<td>- 4/5/2012 – “fell backward”</td>
</tr>
<tr>
<td>A. Designated employees of each agency will enter specified information into the General Events Reporting section of the secure website operated under contract by Therap Services within 2 business days of the occurrence or knowledge by the reporting agency of any of the following defined events in which DDSD requires reporting: Chocking, Missing Person, Suicide Attempt or Threat, Restraint related to Behavior, Serious Injury including Skin Breakdown, Fall (with or without injury), Out of Home Placement and Infections...Providers shall utilize the “Significant Events Reporting System Guide” to assure that events are reported correctly for DDSD tracking purposes. At providers' discretion additional events may be tracked</td>
<td>- 4/19/2012 – “fell backward”</td>
</tr>
<tr>
<td>When the Agency Nurse was asked about reporting in the General Events Reporting System, the following was reported:</td>
<td>- 6/20/2012 – “fell back on floor”</td>
</tr>
<tr>
<td>- Administrator (#59) stated it was the nurses, (#60 and #62), who were designated.</td>
<td>- 7/16/2012 – “stood up and came down on knees.”</td>
</tr>
<tr>
<td>When the Agency Nurse was asked about reporting PRN medication errors in the General Events Reporting System, the following was reported:</td>
<td>- 9/20/2012 – “went to floor”</td>
</tr>
<tr>
<td>- #60 reported they do not complete the General Events Reporting for PRN medications. Per DDSD General Event Reporting Policy (January 1, 2012) stated:</td>
<td>- 10/27/2012 – “fell out of bed”</td>
</tr>
</tbody>
</table>
within the Therap General Events Reporting which are not required by DDSD such as medication errors.

B. General Events Reporting does not replace agency obligations to report abuse, neglect, exploitation and other reportable incidents in compliance with policies and procedures issued by the Department's Incident Management Bureau of the Division of Health Improvement.

“Any medication events that result in a breach of the five “Rs”, mainly right person, right medication, right time, right dose and right route. The types of medication errors are: wrong individual, wrong medication (which includes a medication given without an order) wrong time, missed dose (omissions), wrong dose, wrong route…”
**Standard of Care**

**Deficiencies**

**Agency Plan of Correction, On-going QA/QI and Responsible Party**

**Date Due**

<table>
<thead>
<tr>
<th>Tag # 1A15.2 and 5I09 Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 2 of 11 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td><strong>Special Health Care Needs:</strong></td>
<td><strong>Provider:</strong></td>
</tr>
<tr>
<td>• <strong>Nutritional Evaluation</strong></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>○ Individual #9 - According to collateral documentation the last evaluation completed was 9/28/2010. Per documentation the IDT discussed discontinuing the Nutritionist, yet chose to keep the 1800 calorie diet. No evidence of current evaluation found indicating Individual is medically/clinically required to have an 1800 calorie diet.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Nutritional Plan</strong></td>
<td>Provider:</td>
</tr>
<tr>
<td>○ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. (Nutritional Consultation was never formally discontinued by the IDT)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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<td></td>
<td></td>
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<tr>
<td>• <strong>Health Care Plans</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>GI Constipation Management</strong></td>
<td></td>
</tr>
<tr>
<td>Individual #10 - According to Electronic Comprehensive Heath Assessment Tool,</td>
<td></td>
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</tbody>
</table>
basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual’s Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be part, 16.b, the individual is required to have a plan. No evidence of a plan found.
documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.
(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare
plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):

(a) Each healthcare plan must include a statement of the person’s healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.

(c) Approaches described in the plan shall be individualized to reflect the individual’s unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

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

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and
<table>
<thead>
<tr>
<th>Training delivery for healthcare plans to assure maximum consistency across settings.</th>
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<tbody>
<tr>
<td>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</td>
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<tr>
<td>(g) All crisis prevention and intervention plans and healthcare plans shall include the individual’s name and date on each page and shall be signed by the author.</td>
</tr>
<tr>
<td>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</td>
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</tbody>
</table>

(4) **General Nursing Documentation**

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.


**CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS**

B. IDT Coordination

(1) Community Inclusion Services Provider Agencies shall participate on the IDT as
specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

**Department of Health Developmental Disabilities Supports Division Policy.**

**Medical Emergency Response Plan Policy**

**MERP-001 eff.8/1/2010**

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

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not…
<table>
<thead>
<tr>
<th>Tag # 1A27 Incident Mgt. Late and Failure to Report</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</strong></td>
<td>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 for 3 of 11 individuals.</td>
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</tr>
</tbody>
</table>
| **A. Duty To Report:** | Individual #1  
- Incident date 9/4/2012. Allegation was Neglect. Incident report was received 9/4/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was, “Unconfirmed-DHI.” | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| (1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. | Individual #3  
- Incident date 7/18/2012. Allegation was Emergency Services. Incident report was received 7/30/2012. Late Reporting. IMB Late and Failure Report indicated incident of Emergency Services was, “Unconfirmed-DHI.” | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| (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: | Individual #7  
- Incident date 3/6/2012. Allegation was Neglect. Incident report was received 8/30/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was, “Unconfirmed-DHI.” |  |
| (a) an environmental hazardous condition, which creates an immediate threat to life or health; or | **Note:** Although these incidents were unconfirmed by DHI, the Agency failed to report to the Division within twenty-four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents. |  |
| (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 |  |  |


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instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.
<table>
<thead>
<tr>
<th>Tag # 1A28 Incident Mgt. System - Policy/Procedure</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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: (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 Based on record review and interview, the Agency did not maintain an incident management policy and procedure, which clearly identifies the reporting process and established timeline set forth by New Mexico Administrative Code 7.1.13. Review of the Agency’s Incident Management Policy and Procedure found no evidence indicating incident reports are to be prepared by the reporter with the most direct knowledge of the incident, nor did it state the incident report form must be received by the Division of Health Improvement 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. When #59 was asked about the Agency’s Incident Management process, the following was reported: • #59 reported the Agency staff are to complete the incident reports and return them to the office. Per the Agency’s “Abuse, Neglect or Exploitation of Consumers” policy and procedures (page 26), states the following: “In all cases of suspected abuse, neglect or exploitation the Administrator will require a preliminary investigation of actions or incidents leading to the suspected abuse or neglect. The Administrator may require further investigative action, including the use of an internal fact-finding committee, referral to the governing body, or any other investigative process deemed appropriate by the Administrator. The Administrator will</td>
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Provider: State your Plan of Correction for the deficiencies cited in this tag here: →

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

Provider: →


Survey Report #: Q.13.3.DDW.D0161.4.001.FCD.01.067
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.

C. Incident Policies: All community based service providers shall maintain policies and procedures, which describe the community based service provider’s immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC.

NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:

report all incidents or unusual occurrences, which have or could threaten the health, safety, or welfare of consumers or staff to the DOH.”

During Interviews with DSP, 1 of 2 DSP was able to accurately describe the Incident Management reporting process. When Direct Support Personnel were asked what State Agencies must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:

- DSP #55 referred to reporting poster and stated, (I would) “call number, assume they would get back with me. I don't know about the paperwork.” Staff was not able to identify either State Agency as which reporting is required for suspected abuse, neglect or exploitation.

When DSP were asked if they needed to make a State Incident Report for Abuse, Neglect, Exploitation or any other reportable incident, did they feel that an incident report could be made without any negative outcomes from the Agency. 2 of 2 staff reported they could make reports without concern.
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.

B. **Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider’s facility. Training shall be conducted in a language that is understood by the employee and volunteer.

C. **Incident Management System Training Curriculum Requirements:**

1. The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable
representative to conduct training, in accordance with the written training curriculum that includes but is not limited to:

(a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property;
(b) informational procedures for properly filing the division's incident management report form;
(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property.
(d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property;
(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and
(f) where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.
<table>
<thead>
<tr>
<th>Tag # 6L13</th>
<th>Community Living Healthcare Reqts.</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<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 1 of 11 individuals receiving Community Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING G. Health Care Requirements for Community Living Services.</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
<td></td>
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<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>• <strong>Review of Psychotropic Medication</strong> ° Individual #10 - According to Annual History and Physical, Individual #10 is to have a medication review every six months. Last medication review was completed 4/2012. No evidence was found for the following time frame to indicate it was completed as required (5/2012 – 1/2013).</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<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:  (a) Provision of health care oversight consistent with these Standards as</td>
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</tbody>
</table>


Survey Report #: Q.13.3.DDW.D0161.4.001.FCD.01.067
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.
Date: November 21, 2014

To: Vicky Lozano, Owner/Administrator
Provider: Casa Alegre
Address: P.O. Box 362
State/Zip: Ruidoso, New Mexico 88355

E-mail Address: mend@windstream.net

Region: Southeast
Survey Date: February 13 – 14, and March 4 – 5, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation; Supported Employment)
Survey Type: Focused

The Division of Health Improvement/Quality Management Bureau is closing your Plan of Correction. All issues are now considered closed.

The Plan of Correction process is now complete.

Sincerely,

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

Q.13.3.DDW.D0161.4.FCD.09.14.343