Date: July 26, 2012

To: Anita Pohl, Director
Provider: A Center for Function and Creativity, Inc.
Address: 10701 Coors Blvd. NW Suite 17
State/Zip: Albuquerque, New Mexico 87114

E-mail Address: cfc_anita@yahoo.com

CC: Danny Cordova, Owner
E-Mail Address dannycordova@yahoo.com

Region: Metro
Routine Survey: November 28 – December 1, 2011
Verification Survey: July 24 – 25, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Inclusion Supports (Adult Habilitation)
Survey Type: Verification
Team Leader: Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Pohl,

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with you Plan of Correction submitted to DHI regarding the Routine Survey on *November 28 – December 1, 2011*. The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

Compliance with Conditions of Participation

However due to the new/repeat deficiencies your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator at 505-699-9356, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Nadine Romero, LBSW

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

Survey Process Employed:

Entrance Conference Date:	July 24, 2012	
Present:	**A Center for Function and Creativity, Inc.** Anita Pohl, Director **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Erica Nilsen, BA Healthcare Surveyor	
Exit Conference Date:	July 25, 2012	
Present:	**A Center for Function and Creativity, Inc.** Anita Pohl, Director **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Erica Nilsen, BA, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	14 1 - *Jackson* Class Members 13 - Non-*Jackson* Class Members 14 - Adult Habilitation
Persons Served Records Reviewed	Number:	14
Direct Support Personnel Interviewed	Number:	3
Direct Support Personnel Records Reviewed	Number:	16
Service Coordinator Records Reviewed	Number:	2

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy & Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Evacuation Drills
- Quality Assurance/Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division

QMB Determinations of Compliance

- "Compliance with Conditions of Participation"
  The QMB determination of "Compliance with Conditions of Participation," indicates that a provider is in compliance with all 'Conditions of Participation,' (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.

- "Partial-Compliance with Conditions of Participation"
  The QMB determination of "Partial-Compliance with Conditions of Participation" indicates that a provider is out of compliance with one (1) to three (3) 'Conditions of Participation.' This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

- "Non-Compliant with Conditions of Participation":
  The QMB determination of "Non-Compliance with Conditions of Participation," indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.

  The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

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

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 business days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

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

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

Agency: **A Center for Function and Creativity, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: Inclusion Supports (Adult Habilitation)
Monitoring Type: Verification Survey
Routine Survey: **November 28 – December 1, 2011**
Verification Survey: **July 24 - 25, 2012**

Standard of Care	November 28 – December 1, 2011 Deficiencies	July 24 - 25, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
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 # 1A26 Consolidated On-line Registry/Employee Abuse Registry	***Condition of Participation Level Deficiency***	**Standard Level Deficiency**
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 14 of 14 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** **Direct Support Personnel (DSP):** • #40 – Date of hire 10/29/2011, completed 11/29/2011. • #41 – Date of hire 12/1/2010, completed 11/29/2011. • #42 – Date of hire 10/29/2011, completed	**New and Repeat Findings:** Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 3 of 19 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** **Direct Support Personnel (DSP):** • #58 – Date of hire 1/18/2012, completed 2/17/2012. • #61 – Date of Hire 6/18/2012, completed 6/21/2012. **Service Coordination Personnel (SC):** • #64 – Date of Hire 5/1/2012, completed 5/15/2012.

B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel	11/29/2011. • #43 – Date of hire 9/11/2011, completed 11/29/2011. • #44 – Date of hire 5/4/2011, completed 11/29/2011. • #45 – Date of hire 6/16/2011, completed 11/29/2011. • #46 – Date of Hire 8/22/2011, completed 11/29/2011. • #47 – Date of hire 3/1/2011, completed 11/29/2011. • #48 – Date of hire 2/17/2011, completed 11/29/2011. • #49 – Date of hire 5/31/2011, completed 11/29/2011. • #50 – Date of hire 10/25/2011, completed 11/29/2011. • #51 – Date of hire 2/3/2011, completed 11/29/2011. **Service Coordination Personnel (SC):** • #52 – Date of hire 10/1/2010, completed 11/29/2011. • #53 – Date of hire 3/1/2011, completed 11/29/2011.	

shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.		

Standard of Care	November 28 – December 1, 2011 Deficiencies	July 24 - 25, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A15.2 & 5I09 - Healthcare Documentation	***Condition of Participation Level Deficiency***	**Standard Level Deficiency**
Developmental 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. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 12 of 16 individual The following were not found, incomplete and/or not current: • Health Assessment Tool (#3 &16) • Medication Administration Assessment Tool (#3 &16) • Health Passport (#1, 2, 3, 8, 10, 11, 14, 15 & 16) • Comprehensive Aspiration Risk Management Plan (#11) • Aspiration Risk Screening Tool (#2, 5, 10, 15 & 16) • **Quarterly Nursing Review of HCP/Crisis Plans:** ◦ None found for 11/2010 - 10/2011 (#2) • **Special Health Care Needs:** • Meal Time Plan ◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.	**Repeat Finding:** Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 14 individuals. The following were not found, incomplete and/or not current: • **Health Care Plans** • *Aspiration* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Skin Wound* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.

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 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	• Nutritional Plan ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #14 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • **Health Care Plans** • *Aspiration* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Skin Wound* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #3 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Gastrointestinal*	

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.	◦ Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Falls* ◦ Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Oral Hygiene* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Pain* ◦ Individual #12 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • **Crisis Plans/Medical Emergency Response Plans** • *Aspiration* ◦ Individual #2 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #3 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Falls*	

(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary	◦ Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Pain* ◦ Individual #12 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.	

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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **B. IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to		

avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.		

Tag # 1A27 Incident Mgt Late & Failure to Report		Standard Level Deficiency
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 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.		**New Finding:** Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 2 of 15 individuals. Individual #2 • Incident date 4/13/2012. Allegation was Abuse. Incident report was received 4/16/2012. Failure to report. IMB Late & Failure Report indicated incident of Abuse was "Confirmed." Individual #17 • Incident date12/15/2011. Allegation was Neglect. Incident report was received 12/15/2011. Failure to report. IMB Late & Failure Report indicated incident of Abuse was "Confirmed."

Standard of Care	November 28 – December 1, 2011 Deficiencies	July 24 – 25, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
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.*		
Tag # 1A08 Agency Case File	Standard Level Deficiency	Completed
Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency	Completed
Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency	Completed
Tag # 5I11.1 Reporting Requirements (CI Quarterly Report Components)	Standard Level Deficiency	Completed
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 # 1A11.1 Transportation Training	Standard Level Deficiency	Completed
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	Completed
Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency	Completed
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Completed
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency	Completed
Tag # 1A32 & 6L14 ISP Implementation	*Condition of Participation Level Deficiency*	Completed
Tag # 1A36 Service Coordination Requirements	Standard Level Deficiency	Completed
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency	Completed

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency	Completed
Tag # 1A29 Complaints / Grievances – Acknowledgement	Standard Level Deficiency	Completed
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.		
Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency	Completed

Date: February 19, 2013

To: Anita Pohl, Director
Provider: A Center for Function and Creativity, Inc.
Address: 10701 Coors Blvd. NW Suite 17
State/Zip: Albuquerque, New Mexico 87114

E-mail Address: cfc_anita@yahoo.com

CC: Danny Cordova, Owner
E-Mail Address dannycordova@yahoo.com

Region: Metro
Routine Survey: November 28 – December 1, 2011
Verification Survey: July 24 – 25, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Inclusion Supports (Adult Habilitation)
Survey Type: Verification

Dear Ms. Pohl,

You have completed all the requirements per the Internal Review Committee (IRC).

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,

Crystal Lopez-Beck

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

Q13.3.75988721.5.001.VS.09.050