Dear Mrs. Bishop-Couch:

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

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

**Compliance with all Conditions of Participation.**

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Nicole Brown, MBA
Nicole Brown, MBA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: February 11, 2013

Present: **Cornucopia Adult Services, Inc.**
Eric McCollon, Program Director

**DOH/DHI/QMB**
Nicole Brown, MBA, Team Lead/Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor

Exit Conference Date: February 14, 2013

Present: **Cornucopia Adult Services, Inc.**
Michelle Bishop-Couch, Chief Executive Officer
Eric McCollon, Program Director
Kurt Forbis, Finance Director
Rosanne Cervantes, Family Living Service Coordinator

**DOH/DHI/QMB**
Nicole Brown, MBA, Team Lead/Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 13
1 - Jackson Class Members
12 - Non-Jackson Class Members
4 - Family Living
12 - Adult Habilitation
4 - Community Access

Total Homes Visited
Number: 4

- Family Living Homes Visited
Number: 4

Persons Served Records Reviewed
Number: 13

Persons Served Interviewed
Number: 7

Persons Served Observed
Number: 6 (Two Individuals did not respond to questions asked by Surveyors and 4 Individuals were not available during the on-site visit)

Direct Support Personnel Interviewed
Number: 12

Direct Support Personnel Records Reviewed
Number: 26

Service Coordinator Records Reviewed
Number: 4

Substitute Care/Respite Personnel Records Reviewed
Number: 5
Administrative Processes and Records Reviewed:

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

CC: Distribution List:

DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
Attachment A

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

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

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued 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
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

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

POC Document Submission Requirements

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

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

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

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status. If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due
--- | --- | --- | ---
**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 | |
|-------------|-------------------|---------------------------|---
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 2 of 13 individuals. | **Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: → |
| CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. | Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: | **Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements: (1) Emergency contact information, including the individual’s address, telephone number, | - **Dental Exam**
° Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. | |
<p>| | ° Individual #10 - As indicated by collateral documentation reviewed, the exam was completed on 8/31/2011. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. | |
| | - <strong>Vision Exam</strong> | |
| | ° Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. | |
| | ° Individual #10 - As indicated by the DDSD | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</td>
</tr>
<tr>
<td>(2)</td>
<td>The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</td>
</tr>
<tr>
<td>(3)</td>
<td>Progress notes and other service delivery documentation;</td>
</tr>
<tr>
<td>(4)</td>
<td>Crisis Prevention/Intervention Plans, if there are any for the individual;</td>
</tr>
<tr>
<td>(5)</td>
<td>A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</td>
</tr>
<tr>
<td>(6)</td>
<td>When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</td>
</tr>
<tr>
<td>(7)</td>
<td>Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</td>
</tr>
<tr>
<td>(8)</td>
<td>The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</td>
</tr>
<tr>
<td>(a)</td>
<td>Complete file for the past 12 months;</td>
</tr>
<tr>
<td>(b)</td>
<td>ISP and quarterly reports from the current and prior ISP year;</td>
</tr>
<tr>
<td>(c)</td>
<td>Intake information from original admission to services; and</td>
</tr>
<tr>
<td>(d)</td>
<td>When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</td>
</tr>
</tbody>
</table>

file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
| NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. 

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. |
<table>
<thead>
<tr>
<th>Tag # 1A08.1</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agency Case File - Progress Notes</strong></td>
<td>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 13 Individuals.</td>
</tr>
</tbody>
</table>

**Community Access Progress Notes/Daily Contact Logs**

**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: →

---


Survey Report #: Q.13.3.DDW.D3796.5.001.RTN.01.073
<table>
<thead>
<tr>
<th>Tag # 1A32 &amp; 6L14 ISP Implementation</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 13 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td>Per Individual's ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Residential Files Reviewed:

**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

Individual #4
- "With assistance as/if needed, will provide the correct amount of food and water for his dogs," is to be completed 3 times per week. Action Step was not being completed at the required frequency for 2/1 – 12, 2013.

- "With assistance as/if needed, will take his dogs for a walk to get the mail," is to be completed 2 times per week. Action Step was not being completed at the required frequency for 2/1 – 12, 2013.
play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]
<table>
<thead>
<tr>
<th>Tag # 6L14</th>
<th>Residential Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 3 of 4 Individuals receiving Family Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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: | • Current Emergency & Personal Identification Information  
  ◦ Did not contain Health Plan (# 2, 7, 11) | | |
| (1) Complete and current ISP and all supplemental plans specific to the individual; | • Annual ISP (#7) | | |
| (2) Complete and current Health Assessment Tool; | • Positive Behavioral Plan (#7) | | |
| (3) Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; | • Occupational Therapy Plan (#11) | | |
| (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); | • Health Care Plans  
  ◦ Pain (#11) | | |
| (5) Data collected to document ISP Action Plan implementation | • Crisis Plan/Medical Emergency Response Plans  
  ◦ Constipation (#11)  
  ◦ Pain (#11) | | |
| | • Progress Notes/Daily Contacts Logs:  
  ◦ Individual #2 - None found for 2/1 – 11, 2013 | | |
<p>| | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(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;</td>
<td></td>
</tr>
<tr>
<td>(7) Physician’s or qualified health care providers written orders;</td>
<td></td>
</tr>
<tr>
<td>(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);</td>
<td></td>
</tr>
<tr>
<td>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</td>
<td></td>
</tr>
<tr>
<td>(a) The name of the individual;</td>
<td></td>
</tr>
<tr>
<td>(b) A transcription of the healthcare practitioner’s prescription including the brand and generic name of the medication;</td>
<td></td>
</tr>
<tr>
<td>(c) Diagnosis for which the medication is prescribed;</td>
<td></td>
</tr>
<tr>
<td>(d) Dosage, frequency and method/route of delivery;</td>
<td></td>
</tr>
<tr>
<td>(e) Times and dates of delivery;</td>
<td></td>
</tr>
<tr>
<td>(f) Initials of person administering or assisting with medication; and</td>
<td></td>
</tr>
<tr>
<td>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.</td>
<td></td>
</tr>
<tr>
<td>(h) For PRN medication an explanation for the use of the PRN must include:</td>
<td></td>
</tr>
<tr>
<td>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and</td>
<td></td>
</tr>
<tr>
<td>(ii) Documentation of the effectiveness/result of the PRN delivered.</td>
<td></td>
</tr>
<tr>
<td>(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</td>
<td></td>
</tr>
</tbody>
</table>
copy must be placed in the agency file on a weekly basis.

(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
### Standard of Care

**Deficiencies**

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

<table>
<thead>
<tr>
<th>CMS Assurance – Qualified Providers</th>
<th>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.</th>
</tr>
</thead>
</table>

**Tag # 1A11.1 Transportation Training**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 4 of 26 Direct Support Personnel.</td>
</tr>
<tr>
<td>No documented evidence was found of the following required training:</td>
</tr>
<tr>
<td>- Transportation (DSP #44, 47, 60, 64)</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: →

---
unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A20 Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 26 Direct Support Personnel.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
<td></td>
</tr>
<tr>
<td>Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td>- Pre- Service (DSP #47)</td>
<td></td>
</tr>
<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
<td>- Foundation for Health &amp; Wellness (DSP #47)</td>
<td></td>
</tr>
<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td>- Person-Centered Planning (1-Day) (DSP #47)</td>
<td></td>
</tr>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for</td>
<td>- Assisting With Medication Delivery (DSP #47)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Participatory Communication &amp; Choice Making (DSP #47)</td>
<td></td>
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<td></td>
<td>- Rights &amp; Advocacy (DSP #47)</td>
<td></td>
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<td></td>
<td>- Level 1 Health (DSP #47)</td>
<td></td>
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<tr>
<td></td>
<td>- Positive Behavior Supports Strategies (DSP #47)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Teaching &amp; Support Strategies (DSP #47)</td>
<td></td>
</tr>
<tr>
<td>Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</td>
<td></td>
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<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
<td></td>
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<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
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<tr>
<td>G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A25 Criminal Caregiver History Screening</td>
<td>Standard Level Deficiency</td>
<td></td>
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<tr>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td><strong>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</strong></td>
<td>Based on record review, the Agency failed to maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 2 of 35 Agency Personnel.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>F. Timely Submission:</strong> Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</strong></td>
<td><strong>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</strong></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td><strong>A. Prohibition on Employment:</strong> A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.</strong> The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</td>
<td>• #44 – Date of hire 12/5/2012.</td>
<td></td>
</tr>
<tr>
<td><strong>A. homicide;</strong></td>
<td>• #64 – Date of hire 12/5/2012.</td>
<td></td>
</tr>
</tbody>
</table>
sexual contact, incest, indecent exposure, or other related felony sexual offenses;

**E.** crimes involving adult abuse, neglect or financial exploitation;

**F.** crimes involving child abuse or neglect;

**G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or

**H.** an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
<table>
<thead>
<tr>
<th>Tag # 1A26</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated On-line Registry/Employee Abuse Registry</td>
<td>Based on record review, the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 2 of 35 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>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. 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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:

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


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

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

<p>| | | |
|   |   |   |</p>
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 1 of 30 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures require all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
</tr>
<tr>
<td>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. <strong>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</strong></td>
<td>- Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (DSP# 57)</td>
<td></td>
</tr>
<tr>
<td>II. POLICY STATEMENTS:</td>
<td>Provider:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>A. Individuals shall receive services from</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey Report #: Q.13.3.DDW.D3796.5.001.RTN.01.073

Page 30 of 47
competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 1A37 Individual Specific Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>
CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.  
C. Orientation and Training Requirements:  
Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:  
(2) **Individual-specific training** for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.  
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:  
A. Individuals shall receive services from competent and qualified staff.  
B. Staff shall complete individual-specific (formerly known as “Addendum B”) training  
| Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 2 of 30 Agency Personnel.  
Review of personnel records found no evidence of the following:  
**Direct Support Personnel (DSP):**  
- Individual Specific Training (DSP #57, 64)  
| 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: →  

requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
### CMS Assurance – Health and Welfare

The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag # 1A05 General Requirements</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures.</td>
</tr>
<tr>
<td><strong>CHAPTER 1</strong> II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Review of Agency policies and procedures found the following:</td>
</tr>
<tr>
<td>A. General Requirements:</td>
<td><strong>No evidence of the following policies and procedures:</strong></td>
</tr>
<tr>
<td>(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</td>
<td>- Human Rights Committee</td>
</tr>
</tbody>
</table>

Provider:

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

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

<table>
<thead>
<tr>
<th>Date Due</th>
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<tbody>
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<td></td>
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</table>
Tag # 1A27 Incident Mgt Late & Failure to Report

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>A. Duty To Report:</td>
<td></td>
</tr>
<tr>
<td>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</td>
<td></td>
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<tr>
<td>(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:</td>
<td></td>
</tr>
<tr>
<td>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
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</tbody>
</table>

Based on the Incident Management Bureau’s Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 2 of 15 individuals.

Individual #14
- Incident date 3/1/2012. Allegation was neglect. Incident report was received 3/9/2012. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”

Individual #15
- Incident date 4/5/2012. Allegation was neglect. Incident report was received 4/6/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”
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 #1A33 Board of Pharmacy - Med Storage</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
</table>
| **New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual** | Based on record review and observation, the Agency did not to ensure proper storage of medication for 1 of 4 individuals.  
Observation included:  
Individual #11  
- Lactulose: expired 12/6/2012. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.  
Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: → |  |
| **E. Medication Storage:**  
1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.  
2. Drugs to be taken by mouth will be separate from all other dosage forms.  
3. A locked compartment will be available in the refrigerator for those items labeled “Keep in Refrigerator.” The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.  
4. Separate compartments are required for each resident’s medication.  
5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.  
6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. |  |
| **H. Controlled Substances (Perpetual Count Requirement)**  
1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, |  |

Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
indicating the following information:
a. date  
b. time administered  
c. name of patient  
d. dose  
e. practitioner’s name  
f. signature of person administering or assisting with the administration the dose  
g. balance of controlled substance remaining.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Name of Patient</th>
<th>Dose</th>
<th>Practitioner’s Name</th>
<th>Signature</th>
<th>Balance</th>
</tr>
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<tbody>
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</tbody>
</table>
### Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on observation, the Agency failed to ensure that each individual’s residence met all requirements within the standard for 3 of 4 Family Living residences.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</td>
<td></td>
</tr>
<tr>
<td><strong>Family Living Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP (#4, 7, 11)</td>
<td></td>
</tr>
<tr>
<td>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#7, 11)</td>
<td></td>
</tr>
</tbody>
</table>

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

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

1. Supported Living Services and Family Living Services providers shall assure that each individual's residence has:
   a. Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;
   b. General-purpose first aid kit;
   c. When applicable due to an individual’s health status, a blood borne pathogens kit;
   d. Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;
   e. Accessible telephone numbers of poison control centers located within the line of sight of the telephone;
   f. Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;
   g. Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and
   h. Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy.
unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
### Tag # 5I36  Community Access Reimbursement

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Assurance – Medicaid Billing/Reimbursement/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.</td>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 4 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

**B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

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

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

**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 4 individuals.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Individual #11 November 2012**

- The Agency billed 24 units of Community Access (H2021 U1) on 11/23/2012. Documentation did not contain the required elements on 11/23. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - No documentation found.

- The Agency billed 16 units of Community Access (H2021 U1) on 11/24/2012. Documentation did not contain the required elements on 11/24. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - No documentation found.

**Provider:**

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


CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS

G. Reimbursement

(1) Billable Unit: A billable unit is defined as one-quarter hour of service.

(2) Billable Activities: The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face, but time spent in non-face-to-face activity may be claimed under the following conditions:

(a) Time that is non-face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual’s ISP, Action Plan;
(b) Time that is non-face-to-face involves outreach and identification and training of community connections and natural supports; and
(c) Non-face-to-face hours do not exceed 10% of the monthly billable hours.

(3) Non-Billable Activities: Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

(a) Time and expense for training service
personnel;
(b) Supervision of agency staff;
(c) Service documentation and billing activities; or
(d) Time the individual spends in segregated facility-based settings activities.
<table>
<thead>
<tr>
<th>Tag # 5I44</th>
<th>Adult Habilitation Reimbursement</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 6 of 12 individuals.</td>
<td></td>
</tr>
</tbody>
</table>
| CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION | Individual #1 October 2012  
- The Agency billed 102 units of Adult Habilitation (T2021 U2) from 10/10/2012 through 10/16/2012. Documentation received accounted for 83 units. | |
| A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. | November 2012  
- The Agency billed 106 units of Adult Habilitation (T2021 U2) from 11/14/2012 through 11/19/2012. Documentation received accounted for 87 units. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: | December 2012  
- The Agency billed 101 units of Adult Habilitation (T2021 U2) from 12/19/2012 through 12/24/2012. Documentation received accounted for 87 units. | |
| (1) Date, start and end time of each service encounter or other billable service interval;  
(2) A description of what occurred during the encounter or service interval; and  
(3) The signature or authenticated name of staff providing the service. | Individual #2 December 2012  
- The Agency billed 76 units of Adult Habilitation (T2021 U1) from 12/5/2012 through 12/11/2012. Documentation received accounted for 50 units. | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| MAD-MR: 03-59 Eff 1/1/2004  
8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to | Individual #3 November 2012  
- The Agency billed 52 units of Adult Habilitation (T2021 U1) from 11/21/2012 through 11/27/2012. Documentation received accounted for 42 units. | |

CHAPTER 5 XVI. REIMBURSEMENT

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

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

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

Individual #6
December 2012
- The Agency billed 93 units of Adult Habilitation (T2021 U1) from 12/19/2012 through 12/24/2012. Documentation received accounted for 85 units. Documentation did not contain the required elements on 12/19. One or more of the following elements was not met:
  - The signature or authenticated name of staff providing the service.

Individual #9
November 2012
- The Agency billed 86 units of Adult Habilitation (T2021 U1) from 11/14/2012 through 11/20/2012. Documentation received accounted for 79 units.

Individual #10
October 2012
- The Agency billed 70 units of Adult Habilitation (T2021 U3) from 10/10/2012 through 10/11/2012. Documentation received accounted for 25 units.

- The Agency billed 61 units of Adult Habilitation (T2021 U3) from 10/12/2012 through 10/16/2012. Documentation received accounted for 45 units.

Individual # 12
October 2012
- The Agency billed 131 units of Adult Habilitation (T2021 U2) from 10/3/2012 through 10/9/2012. Documentation received accounted for 116 units.

- The Agency billed 102 units of Adult...
<table>
<thead>
<tr>
<th>Month</th>
<th>Agency Billing Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2012</td>
<td>- The Agency billed 122 units of Adult Habilitation (T2021 U2) from 10/31/2012 through 11/6/2012. Documentation received accounted for 111 units.</td>
</tr>
<tr>
<td></td>
<td>- The Agency billed 76 units of Adult Habilitation (T2021 U2) from 11/21/2012 through 11/27/2012. Documentation received accounted for 66 units.</td>
</tr>
<tr>
<td>December 2012</td>
<td>- The Agency billed 70 units of Adult Habilitation (T2021 U2) from 12/19/2012 through 12/24/2012. Documentation received accounted for 66 units.</td>
</tr>
</tbody>
</table>
Date: May 31, 2013

To: Michelle Bishop-Couch, Chief Executive Officer
Provider: Cornucopia Adult Services, Inc.
Address: 2002 Bridge SW
State/Zip: Albuquerque, New Mexico 87105

E-mail Address: Michelle@cornucopia-ads.org

Board Chair: Curt Schuyler, Board President
E-Mail Address: CurtSchuyler@prodigy.com

Region: Metro
Survey Date: February 11 - 14, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Family Living) and Community Inclusion Supports (Adult Habilitation, Community Access)
Survey Type: Routine

Dear Mrs. Bishop-Couch:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

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