Date: August 10, 2012

To: David Turner, Director
Provider: Creative Careers
Address: 2403 San Mateo Blvd NE Ste. 11
State/Zip: Albuquerque, NM 87110

E-mail Address: cristorey7@yahoo.com

Region: Metro
Survey Date: July 30 - 31, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Inclusion Supports (Supported Employment)
Survey Type: Routine
Team Leader: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Nadine Romero, LBSW, Division of Health Improvement/Quality Management Bureau

Dear Mr. Turner;

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,

Jennifer Bruns, BSW

Jennifer Bruns, BSW  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: July 30, 2012

Present:

Creative Careers
Lorri Dow-Doss, Service Coordinator/Job Coach

DOH/DHI/QMB
Jennifer Bruns, BSW, Team Lead/Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor

Exit Conference Date: July 31, 2012

Present:

Creative Careers
David Turner, Director/Service Coordinator

DOH/DHI/QMB
Jennifer Bruns, BSW, Team Lead/Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 7
0 - Jackson Class Members
7 - Non-Jackson Class Members
7 - Supported Employment

Persons Served Records Reviewed
Number: 7

Persons Served Interviewed
Number: 4

Persons Served Observed
Number: 3 (3 Individuals were not available during the on-site survey.)

Direct Support Personnel Interviewed
Number: 5

Direct Support Personnel Records Reviewed
Number: 6

Service Coordinator Records Reviewed
Number: 2

Administrative Files Reviewed
- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Evacuation Drills
- Quality Assurance / Improvement Plan
CC: Distribution List:  
DOH - Division of Health Improvement  
DOH - Developmental Disabilities Supports Division  
DOH - Office of Internal Audit  
HSD - Medical Assistance Division
Attachment A

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your POC:

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
   a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
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.
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.
<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><strong>CMS Assurance – Service Plans: ISP Implementation</strong> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
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</tbody>
</table>

**Tag # 1A08 Agency Case File**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 4 of 9 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td>- ISP Signature Page (#1)</td>
<td></td>
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<tr>
<td>- Positive Behavioral Plan (#1)</td>
<td></td>
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<tr>
<td>- Positive Behavioral Crisis Plan (#8)</td>
<td></td>
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<tr>
<td>- Documentation of Guardianship/Power of Attorney (#1)</td>
<td></td>
</tr>
<tr>
<td>- Dental Exam</td>
<td></td>
</tr>
<tr>
<td>- Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</td>
<td></td>
</tr>
<tr>
<td>- Vision Exam</td>
<td></td>
</tr>
<tr>
<td>- Individual #6 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

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

(2) The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);

(3) Progress notes and other service delivery documentation;

(4) Crisis Prevention/Intervention Plans, if there are any for the individual;

(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;

(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and

(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.

(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:

   (a) Complete file for the past 12 months;

   (b) ISP and quarterly reports from the current and prior ISP year;

   (c) Intake information from original admission to services; and

   (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

<table>
<thead>
<tr>
<th>Names and telephone numbers of relatives, or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</td>
</tr>
<tr>
<td>(3) Progress notes and other service delivery documentation;</td>
</tr>
<tr>
<td>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</td>
</tr>
<tr>
<td>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</td>
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<td>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</td>
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<td>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</td>
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<td>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</td>
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<td>(a) Complete file for the past 12 months;</td>
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<tr>
<td>(b) ISP and quarterly reports from the current and prior ISP year;</td>
</tr>
<tr>
<td>(c) Intake information from original admission to services; and</td>
</tr>
<tr>
<td>(d) 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>

Individual #9 - As indicated by collateral documentation reviewed, exam was completed 11/2011. Follow-up was to be completed in 2 months. No evidence of follow-up found.
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. **Documentation of test results**: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
## Standard of Care

<table>
<thead>
<tr>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Qualified Providers</strong> – 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.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>

### Tag # 1A20 Direct Support Personnel Training

Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 6 Direct Support Personnel.

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

- Person-Centered Planning (1-Day) (DSP #40)

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

- **C. Orientation and Training Requirements:**
  - Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:
    1. Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and
    2. Individual-specific training for each

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Survey Report #: Q.13.1.DDW.61285854.5.001.RTN.1.233
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 requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

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.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.

H. Staff shall complete and maintain certification in a DDSD-approved medication course in
accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
### Tag # 1A22  Agency Personnel Competency

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

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on interview, the Agency failed to ensure that training competencies were met for 2 of 6 Direct Support Personnel.</td>
</tr>
<tr>
<td><strong>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</strong></td>
</tr>
<tr>
<td>• DSP #45 did not verbalize the Individual required a Health Care Plan for history of neuroleptic malignant syndrome, as indicated by the Electronic Comprehensive Health Assessment Tool (eCHAT). (Individual #6)</td>
</tr>
<tr>
<td><strong>When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:</strong></td>
</tr>
<tr>
<td>• DSP #40 stated, &quot;No.&quot; As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plans for Seizures. (Individual #1)</td>
</tr>
<tr>
<td>• DSP #40 did not verbalize the Individual required a Medical Emergency Response Plan for history of neuroleptic malignant syndrome, as indicated by the Electronic Comprehensive Health Assessment (eCHAT). (Individual #6)</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: → |


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(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

(5) Direct service Provider Agencies of Respite Services, Substitute Care, Personal Support Services, Nutritional Counseling, Therapists and Nursing shall demonstrate basic knowledge of developmental disabilities and have training or demonstrable qualifications related to the role he or she is performing and complete individual specific training as required in the ISP for each individual he or she support.

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:
   (a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;
   (b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and
   (c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

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. |  |  |


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### Tag # 1A25 Criminal Caregiver History Screening

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to maintain documentation indicating no &quot;disqualifying convictions&quot; or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 8 Agency Personnel.</td>
<td></td>
</tr>
<tr>
<td>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</td>
<td></td>
</tr>
<tr>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
</tr>
<tr>
<td>• #45 – Date of hire 2/12/2008</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</th>
</tr>
</thead>
<tbody>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</th>
</tr>
</thead>
<tbody>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> homicide;</td>
</tr>
<tr>
<td><strong>B.</strong> trafficking, or trafficking in controlled substances;</td>
</tr>
<tr>
<td><strong>C.</strong> kidnapping, false imprisonment, aggravated assault or aggravated battery;</td>
</tr>
<tr>
<td><strong>D.</strong> rape, criminal sexual penetration, criminal</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 # 1A36 Service Coordination 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 ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators.</td>
</tr>
</tbody>
</table>

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

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

1. Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and

**NMAC 7.26.5.7** “service coordinator”: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the

| Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |


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community service provider agency

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

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;

(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;

(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;

(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
### Standard of Care

**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 # 1A03 CQI System

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to implement their Continuous Quality Management System as required by standard. The following was not found, not current and or incomplete:</td>
<td></td>
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</tr>
<tr>
<td>- The Agency’s CQI Plan did not contain the following components:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- (3) Trends in achievement of individual outcomes in the Individual Service Plans;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- (4) Trends in medication and medical incidents leading to adverse health events;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
(3) community based service providers


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providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A15 Healthcare Documentation - Nurse Contract/Employee</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 and interview, the Agency failed to provide an employed or contracted licensed registered nurse.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td>Review of Agency records found no evidence of an employed or contracted nurse.</td>
<td></td>
</tr>
<tr>
<td>E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
<td>When #46 was asked if the Agency had an employed or contracted licensed registered nurse the following was reported:</td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>- #46 reported the agency did have a nurse they contract with, but continued, “I don’t have anything written up or have the license for the nurse.” In addition #46 reported the Agency staff utilizes the various residential nurses for any issues or concerns they may have regarding the individuals.</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6 VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td>Note: Current license was verified for the nurse.</td>
<td></td>
</tr>
<tr>
<td>K. Nursing Requirements and Roles</td>
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</tr>
<tr>
<td>(1) All Community Living Service Provider Agencies are required to have a registered nurse (RN) on staff. The agency nurse may be an employee or a sub-contractor.</td>
<td></td>
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<tr>
<td>(3) A Community Living Support Provider Agency shall not use a licensed practical nurse (LPN) without a registered nurse (RN) supervisor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag #</td>
<td>Healthcare Documentation</td>
<td>Standard Level Deficiency</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| 1A15.2 & 5I09 | **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 complete these assessments. | Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 9 individuals.  
The following were not found, incomplete and/or not current:  
- Electronic Comprehensive Health Assessment Tool (eCHAT) Summary Page (#6)  
- Healthcare Passport (#6)  
- Health Care Plans  
  - Aspiration  
    - Individual #4 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.  
  - Falls  
    - Individual #4 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.  
  - Gastro Intestinal  
    - Individual #4 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.  
  - History of Neuroleptic Malignant Syndrome  
    - Individual #6 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. | State your Plan of Correction for the deficiencies cited in this tag here:  
Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:  
Provider: |


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assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,

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</tbody>
</table>

- Neurological (Cerebral Shunt)
  - Individual #3 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
- Respiratory
  - Individual #1 - 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
  - Respiratory
    - Individual #1 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) **Health related plans**

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.

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

(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.

(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.

(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):

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

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

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

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

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

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

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual’s name and date on each page and shall be signed by the author.
(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation

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

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


CHAPTER 5  IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

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

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.
Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff. 8/1/2010

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
### Tag # 1A27 Incident Mgt Late & Failure to Report

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on the Incident Management Bureau’s Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 10 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>Individual #10</strong></td>
<td></td>
</tr>
<tr>
<td>• Incident date 7/01/2011. Allegation was Exploitation. Incident report was received 8/01/2011. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</td>
<td></td>
</tr>
</tbody>
</table>

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

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instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.
<table>
<thead>
<tr>
<th>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><strong>CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability</strong> –</td>
<td>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></td>
<td></td>
</tr>
<tr>
<td><strong>TAG #1A12 All Services Reimbursement (No Deficiencies)</strong></td>
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<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Chapter 1.  III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Billable Units:</strong> The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</td>
<td></td>
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<td></td>
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<tr>
<td>(2) A description of what occurred during the encounter or service interval; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Billing Community Inclusion (Supported Employment) services was reviewed for 9 of 9 individuals. Progress notes and billing records supported billing activities for the months of March, April and May of 2012.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Mr. Turner:

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