Date: November 19, 2012

To: Patsy Romero, Chief Operating Officer
Provider: Easter Seals El Mirador
Address: 10 A Van Nu Po
State/Zip: Santa Fe, New Mexico 87508

E-mail Address: promero@eselm.org

Region: Northeast
Survey Date: October 16 – 17 & 26, 2012
Program: Developmental Disabilities Waiver & ICF/MR Health & Safety Checks
Service: DDW Community Living (Supported Living & Independent Living) & DDW Community Inclusion (Adult Habilitation & Supported Employment)
Survey Type: Focused
Team Leader: Stephanie R. Martinez de Berenger, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Cindy Nielsen, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division Health Improvement/Quality Management Bureau; Erica Nilsen. BA, Healthcare Surveyor, Division Health Improvement/Quality Management Bureau; Fabian Lopez, LBSW, Community Services Coordinator, Developmental Disabilities Supports Division & Linda Dwyer, Community Services Case Manager, Developmental Disabilities Support Division

Dear Ms Romero;

The Division of Health Improvement/Quality Management Bureau has completed a focused compliance survey of the services identified above. The purpose of the focused 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 contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

The specific focus of the survey was to determine compliance with Health and Safety Oversight, Medication Storage, Representative Payee Oversight and Assurance of Individual needs being met.

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

Partial Compliance with Conditions of Participation

This determination is based on non compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

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

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

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

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

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

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

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

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

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

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

Please call the Plan of Correction Coordinator at 505-699-9356 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,

Stephanie R. Martinez de Berenger, MPA

Stephanie R. Martinez de Berenger, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement/Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	October 16, 2012	
Present:	**<u>Easter Seals El Mirador – Alcade, New Mexico</u>** Gary V. Maestas, Service Coordinator **<u>DOH/DHI/QMB</u>** Stephanie R. Martinez de Berenger, MPA, Team Lead/Healthcare Surveyor **<u>DDSD – Northeast Regional Office</u>** Linda Dwyer, Community Services Case Manager Fabian Lopez, Community Services Coordinator	
Exit Conference Date:	October 17, 2012	
Present:	**<u>Easter Seals El Mirador – Alcade, New Mexico</u>** Patsy Romero, Chief Operating Officer (via phone) Renee Ulibarri, House Manager Jennifer Wadley, Quality Management Coordinator Gary V. Maestas, Service Coordinator Alexandra Salazar, House Manager Diana Cuevas-Martinez, Case Manager Albinita Muniz, Service Coordinator Katy Evans, Day Services Manager **<u>DOH/DHI/QMB</u>** Stephanie R. Martinez de Berenger, MPA, Team Lead/Healthcare Surveyor Cyndie Nielsen, RN, Healthcare Surveyor **<u>DDSD – Northeast Regional Office</u>** Linda Dwyer, Community Services Case Manager Fabian Lopez, Community Services Coordinator	
Total Homes Visited	Number:	6
❖ Supported Homes Visited	Number:	2
❖ Independent Homes Visited	Number:	1
❖ ICF/MR Homes Visited	Number:	3
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	6 *5 - Jackson Class Members* 1 - Non-Jackson Class Members ***<u>DD Waiver:</u>*** 2 - Supported Living 1 – Independent Living 3 - Adult Habilitation 1 - Supported Employment

		ICF/MR Health & Safety Visits:
		3 – ICF/MR
Persons Served Records Reviewed	Number:	3
Persons Served Interviewed	Number:	3
Direct Support Personnel Interviewed	Number:	5 (3 DDW DSP & 2 ICF/MR DSP)
Direct Support Personnel Records Reviewed	Number:	15
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
- Human Rights Notes and/or Meeting Minutes Evacuation Drills
- Quality Assurance / Improvement Plan
- Representative Payee Accounts and Daily Petty Cash receipts

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.

Attachment B

Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency's operational policies and procedures, Quality Management system and Medicaid billing and reimbursement process.)

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: (Safety)** Individuals have the right to live and work in a safe environment.

Condition of Participation:

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

QMB Determinations of Compliance

<u>Compliance with Conditions of Participation</u>

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.

<u>Partial-Compliance with Conditions of Participation</u>

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 <u>repeat</u> 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.

<u>Non-Compliance with Conditions of Participation</u>

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Easter Seals El Mirador - Northeast Region**
Program: Developmental Disabilities Waiver & ICF/MR Health & Safety Checks
Service: DDW Community Living (Supported Living & Independent Living) & DDW Community Inclusion (Adult Habilitation & Supported Employment)
Monitoring Type: Focused Survey
Date of Survey: **October 16 – 17 & 26, 2012**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A32 & 6L14 ISP Implementation	**Condition of Participation Level Deficiency**		
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. 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated outcome and action plan for 1 of 3 individuals. Per Individual's ISP and other collateral documentation the following was found with regards to the implementation of the ISP: **Administrative Files Reviewed:** Individual #3: • As indicated by the documentation reviewed Individual #3 is to receive the following services from Easter Seals el Mirador: Independent Living Services, Adult Habilitation Services and Supported Employment Services. Individual #3 did not receive any of these stated services from 10/8/2012 through 10/16/2012.	**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: →	

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. D. The intent is to provide choice and obtain opportunities for individuals to live, work and 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]	**When Agency personnel were asked why the individual had not received services the following was reported:** • #56 reported the individual did not have a current budget in place therefore the agency stopped services. Through further research and confirmation from Molina, Surveyors were able to determine Individual #3 did have a current budget effective 10/6/2012. Therefore, the Individual should have had services implemented during this time period. No evidence was found indicating the agency attempted to obtain the budget prior to discontinuing services. Per Individual's ISP the following was found with regards to the implementation of the ISP Outcomes: **Administrative Files Reviewed:** **Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found for 10/8/2012 – 10/12/2012. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • None found for 10/8/2012 – 10/12/2012. **Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3		

	• None found for 10/8/2012 - 10/12/2012.		

Tag # 6L04 Community Living Scope of Service	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. II. SCOPE OF COMMUNITY LIVING SERVICES**. **A.** The scope of Community Living Services includes, but is not limited to the following as identified by the IDT: (1) Assist with money management, including financial record keeping; (2) Assistance to attain and maintain safe and sanitary living conditions that may include general housekeeping, shopping, washing and drying laundry; (3) Assistance to maintain activities of daily living such as bathing, eating, meal preparation, dressing, and individual hygiene; (4) Assistance with mobility and orientation in community integration, access and utilization of natural supports (5) Assistance in developing and maintaining social, spiritual and individual relationships, to include the development of generic and natural supports of his or her choosing; (6) Assistance to access recreational and leisure activities; (7) Assistance in access to training and educational opportunities on self-advocacy and sexuality; (8) Implementation of the ISP Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable; (9) Assistance in developing health	Based on interview, record review and observation, the Agency failed to provide Community Living Services within the Scope of Service for 1 of 3 individuals. **Record Review found:** • The Agency failed to provide Independent Living, Adult Habilitation & Supported Employment Services from 10/8–16/2012. Surveyors contacted Molina Utilization Review who then verified Individual #3 had an approved budget starting 10/6/2012 through 10/5/2013; therefore services should have not stopped for 10/8 – 10/16/2012. **Observation of Individual #3 services found the Agency failed to provide the following:** (6) Assistance to access recreational and leisure activities from 10/8–16/2012 (8) Implementation of the ISP Therapy, Speech Language Pathology, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans from 10/8 – 16/2012. (10) Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and therapy appointments from 10/8 – 16/2012. **When Agency personnel were asked why the individual had not received services the following was reported:** • #56 reported the individual did not have a current budget in place therefore the agency stopped services.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

maintenance supports, as well as monitoring the effectiveness of such supports; (10) Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and therapy appointments; (11) Assistance in medication management and pharmacy needs in accordance with the DDSD's Medication Assessment and Delivery Policy; (12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/ intervention plans; (13) Support individuals to participate in the development of house rules, schedules and planned activities; and (14) For individuals with a HAT score of 5 or 6, the agency nurse shall participate in the annual ISP meeting and any other IDT meetings called to address a change in health condition/new diagnosis. Such participation will preferably occur in person or by phone, but if that is not possible, may occur via provision of information to the team prior to the meeting with follow up contact afterwards.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	**Standard Level Deficiency**		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. 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	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 1 of 15 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** **Direct Support Personnel (DSP):** • #40 – Date of hire 06/20/2007, completed 08/24/2007.	**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: →	

services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider**			

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
Service Domain – Health Safety 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	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health	Based on record review, the Agency failed to implement their Continuous Quality Management System as required by standard. • Review of the findings found during the on-site survey (October 16 –17, 2012) and as reflected in this report of findings the Agency had deficiencies at the Condition of Participation level noted, which indicates the CQI plan provided by Agency was not being used to fully or successfully identify and improve systems within the agency. CQI failed to ensure: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans;	**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; **(4)** community based service providers			

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.			

Tag # 1A05 General Requirements	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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. **A. General Requirements:** (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.	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. Review of Agency policies & procedures found the following: **The following policies and procedures showed no evidence of being reviewed every three years or being updated as needed:** • "Assurance of Human Rights Policy & Procedure" - Last reviewed May 2008 . • "Notification of Participant Emergency Policy & Procedure" - Last reviewed May 2008. • "Participants Finances Policy & Procedure" – Last reviewed "May 2007/May 2008."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 3 Individuals. Individual #2 October 2012 No effectiveness was noted on the Medication Administration Record for the following PRN medication: • Albuterol 0.083 – PRN – 10/11/2012 (given 1 time) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Olanzapine 2.5mg (PRN)	**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: →	

(c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include:			

(i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24 hour period. **Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure			

that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication.			

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006 C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).			

Tag # 1A27.2 Duty to Report - IR Filed During On-Site and/or IR Not Reported by Provider	Standard Level Deficiency		
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written	Based on record review, observation and interview, 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 3 Individuals. **During the on-site survey October 16 - 17, 2012, Surveyors observed the following:** • During the on-site home visit on 10/17/2012, as Surveyors were inquiring about the services for Individual #3, the Individual's guardian reported the following to Surveyors; They (Individual and guardian) were told by Service Coordinator #56 that the individual had to, "stay home because she is over budget." The guardian additionally reported, the individual is not eating, appears sad and wants to go to Adult Habilitation. **During the Agency record review the following was confirmed:** • The Agency failed to provide Independent Living, Adult Habilitation & Supported Employment Services from 10/8–16/2012. Surveyors contacted Molina Utilization Review who then verified Individual #3 had an approved budget starting 10/6/2012 through 10/5/2013; therefore services should have not stopped for 10/8–10/16/2012. **As a result of what was observed and reported the following incident(s) was reported:** Individual #3	**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: →	

correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number. **(2) Division Incident Report Form and Notification by Community Based Service Providers:** The community based service provider shall report incidents utilizing the division's incident report form consistent with the requirements of the division's incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division's incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.	• A State Incident Report for Neglect was filed on October 17, 2012.		

Tag # 1A33 Board of Pharmacy - Med Storage	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance,	Based on record review and observation, the Agency failed to ensure proper storage of medication for 1 of 3 individuals. Observation included: Individual #2 • Azithromycin 200mg/5ml expired 09/2012. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Azithromycin 250mg expired 11/2011. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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.			

Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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	Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 3 Supported Living residences. The following items were not found, not functioning or incomplete: **Supported Living Requirements:** • 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 (#1) • 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 (#1)	**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: →	

unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.			

<table>
<tr><th>Standard of Care</th><th>Deficiencies</th><th>Agency Plan of Correction, On-going QA/QI & Responsible Party</th><th>Date Due</th></tr>
<tr><td colspan="4">Service Domain – Administrative Oversight: Medicaid Billing/Reimbursement – 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></tr>
<tr><td>Tag # 6L28 Independent Living Reimbursement</td><td>Standard Level Deficiency</td><td></td><td></td></tr>
<tr><td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007
CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION
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:</td><td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Independent Living Services for 1 of 3 individuals.

Individual #3
July 2012
• The Agency billed 1 unit of Independent Living (T2030 U1) from 7/1/2012 through 7/31/2012. Documentation did not contain the required elements on 7/2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26 & 27, 2012. Documentation received accounted for 0 units. One or more of the following elements was not met:
➢ The signature or authenticated name of staff providing the service.

August 2012
• The Agency billed 1 unit of Independent Living (T2030 U1) from 8/1/2012 through 8/31/2012. Documentation did not contain the required elements on 8/1, 2, 3, 6, 7, 10, 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30 & 31, 2012. Documentation received accounted for 0 units. One or more of the following elements was not met:
➢ The signature or authenticated name of staff providing the service.

September 2012
• The Agency billed 1 unit of Independent</td><td>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: →</td><td></td></tr>
</table>

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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** D. Reimbursement for Independent Living Services: The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.	Living (T2030 – U1) from 9/1/2012 through 9/28/2012. Documentation did not contain the required elements on 9/4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 20, 21, 24, 25, 26, 27 & 28/2012. Documentation received accounted for 0 units. One or more of the following elements was not met: ➢ The signature or authenticated name of staff providing the service.		

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

BRAD McGRATH, INTERIM SECRETARY

Date: December 18, 2012

To: Patsy Romero, Chief Operating Officer
Provider: Easter Seals El Mirador
Address: 10 A Van Nu Po
State/Zip: Santa Fe, New Mexico 87508

Region: Northeast
Survey Date: October 16 – 17 & 26, 2012
Program: Developmental Disabilities Waiver & ICF/MR Health & Safety Checks
Service: DDW Community Living (Supported Living & Independent Living) & DDW Community Inclusion (Adult Habilitation & Supported Employment)
Survey Type: Focused

Dear Ms Romero;

Your request for a Reconsideration of Findings was received on December 4, 2012. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A27.2
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. When this incident was discovered on 10/16/12 the survey team did inform Gary Maestes, Service Coordinator on the same day. Once a reportable incident is discovered, the QMB is required to report this to DHI/IMB; not refer it back to the provider.

Regarding Tag # 6L04
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. No community living notes were supplied as part of the IRF.

Regarding Tag # 1A32/6L14
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied the citation will be modified to state the following:

Individual #3:

- As indicated by the documentation reviewed Individual #3 is to receive the following services from Easter Seals el Mirador: Independent Living Services, Adult Habilitation Services and Supported Employment Services. Individual #3 did not receive any of these stated services from 10/8/2012 through 10/12/2012. *(Rather than 10/8/12 through 10/16/12)*

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

Thank you.
Respectfully,
Scott Good, Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

NEW MEXICO CENTENNIAL 1912-2012

DIVISION OF HEALTH IMPROVEMENT
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • http://www.dhi.health.state.nm.us

Date: May 10, 2013

To: Patsy Romero, Chief Operating Officer
Provider: Easter Seals El Mirador
Address: 10 A Van Nu Po
State/Zip: Santa Fe, New Mexico 87508

E-mail Address: promero@eselm.org

Region: Northeast
Survey Date: October 16 – 17 & 26, 2012
Program: Developmental Disabilities Waiver & ICF/MR Health & Safety Checks
Service: DDW Community Living (Supported Living & Independent Living) & DDW Community Inclusion (Adult Habilitation & Supported Employment)
Survey Type: Focused

Dear Ms Romero;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

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

Q.13.4.DDW.D0974.2.001.FCD.09.130