Dear Ms. Herrera;

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:**

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


Survey Report #: Q.13.3/DDW.A0413.2/5.001.RTN.01.094
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,

Erica Nilsen, BA

Erica Nilsen, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: February 25, 2013

Present:

**Expressions of Life, Inc.**
Carol Lynn Herrera, Executive Director

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Exit Conference Date: February 28, 2013

Present:

**Expressions of Life, Inc.**
Carol Lynn Herrera, Executive Director
J. Herrera, Finance Administrator
Ashley Candelaria, Administrative Assistant
Jade Contrucci, Data Entry
Jennifer Menke, Service Coordinator
JoAnn Gonzales, Service Coordinator
Mary Jean Gonzales, Quality Assurance Clerk

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Amanda Castaneda, MPA, Healthcare Surveyor
Cynthia Nielsen, BSN, RN, Healthcare Surveyor
Cynthia Nielsen, BSN, RN, Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor
Corrina Strain, BSN, RN, Healthcare Surveyor

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 24

- 4 - Jackson Class Members
- 20 - Non-Jackson Class Members
- 21 - Family Living
- 3 - Independent Living

Total Homes Visited
Number: 21

Family Living Homes Visited
Number: 21

Persons Served Records Reviewed
Number: 24

Persons Served Interviewed
Number: 10

Persons Served Observed
Number: 14 (13 individuals were unavailable at the time of survey, 1 individual chose not to participate in interview)

Direct Support Personnel Interviewed
Number: 24
Direct Support Personnel Records Reviewed Number: 132  (Note: 3 Service Coordinators are also Family Living Providers; numbers are duplicated for that count)

Service Coordinator Records Reviewed Number: 5

Substitute Care/Respite Personnel Records Reviewed Number: 148

Administrative Processes and Records Reviewed:

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

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

Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094
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.
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 processes.)

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

**Service Domain: Level of Care**

Condition of Participation:

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

**Service Domain: Plan of Care**

Condition of Participation:

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

Condition of Participation:

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

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

**Service Domain: Qualified Providers**

Condition of Participation:

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

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

**Service Domain: Plan of Care**

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

**Service Domain: Health, Welfare and Safety**

Condition of Participation:

6. **Individual Health, Safety and Welfare**: (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

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

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

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

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

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

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

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

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status. If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and 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>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Tag # 1A08 Agency Case File** Standard Level Deficiency | Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 1 of 24 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
• Occupational Therapy Plan (#10) | Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: → | |

**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.

**D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:

1. Emergency contact information, including the individual’s address, telephone number,
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.
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.
Tag # 1A32 and 6L14
Individual Service Plan Implementation

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 6 of 24 individuals.</td>
<td></td>
</tr>
<tr>
<td>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Administrative Files Reviewed:</td>
<td></td>
</tr>
<tr>
<td>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Individual #8</td>
<td></td>
</tr>
<tr>
<td>• &quot;Shop to find DVDs he wants at the price he wants,&quot; is to be completed 2 times per month. Outcome Statement was not being completed at the required frequency as indicated in the ISP for 12/2012.</td>
<td></td>
</tr>
<tr>
<td>• &quot;Sort through old VCR tapes,&quot; is to be completed 4 times per month. Action Step was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012</td>
<td></td>
</tr>
<tr>
<td>Individual #19</td>
<td></td>
</tr>
<tr>
<td>• Per Live Outcome: Action Steps for, &quot;Will practice entering his monthly schedule in his planner,&quot; is to be completed 3 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012 - 12/2012.</td>
<td></td>
</tr>
</tbody>
</table>

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 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]

<table>
<thead>
<tr>
<th>Individual #</th>
<th>Action Step</th>
<th>Frequency</th>
<th>ISP for</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>“Will independently sweep the kitchen floor,”</td>
<td>2 times per week</td>
<td>11/2012</td>
<td>Not completed</td>
</tr>
<tr>
<td>2</td>
<td>None found for 2/1/2013 – 2/26/2013.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>“Will follow her visual schedule established by BSC,”</td>
<td>1 time per day</td>
<td>2/1/2013 - 2/25/2013.</td>
<td>Not completed</td>
</tr>
<tr>
<td>10</td>
<td>None found for 2/1/2013 – 2/25/2013.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Residential Files Reviewed:**

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

Individual #2
- None found for 2/1/2013 – 2/26/2013.

Individual #4
- “Will follow her visual schedule established by BSC,” is to be completed 1 time per day. Action Step was not being completed at the required frequency as indicated in the ISP for 2/1/2013 - 2/25/2013.

Individual #10
<table>
<thead>
<tr>
<th>Tag # 6L14 Residential Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 11 of 21 Individuals receiving Family Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</strong></td>
<td>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
</tbody>
</table>
| **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: |  - **Current Emergency and Personal Identification Information**  
  - Did not contain Pharmacy Information (#2)  
  - Did not contain Physician Information (#2)  
  - **Positive Behavioral Plan (#17, 21)**  
  - **Positive Behavioral Crisis Plan (#3, 17, 21)**  
  - **Speech Therapy Plan (#15, 23)**  
  - **Occupational Therapy Plan (#4)**  
  - **Physical Therapy Plan (#3, 4, 10, 12)**  
  - **Special Health Care Needs**  
  - Nutritional Plan (#3, 17, 24)  
  - Comprehensive Aspiration Risk Management Plan (#6, 12, 24)  
  - **Progress Notes written by DSP and/or Nurses regarding Health Status:**  
  - Individual #4 - None found for February 1 – 25, 2013 | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| (1) Complete and current ISP and all supplemental plans specific to the individual; | **Provider:** | |
| (2) Complete and current Health Assessment Tool; | | |
| (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; | | |
| (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); | | |
| (5) Data collected to document ISP Action Plan | | |
(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
(7) Physician’s or qualified health care providers written orders;
(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);
(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (a) The name of the individual;
   (b) A transcription of the healthcare practitioner’s prescription including the brand and generic name of the medication;
   (c) Diagnosis for which the medication is prescribed;
   (d) Dosage, frequency and method/route of delivery;
   (e) Times and dates of delivery;
   (f) Initials of person administering or assisting with medication; and
   (g) An explanation of any medication irregularity, allergic reaction or adverse effect.
   (h) For PRN medication an explanation for the use of the PRN must include:
      (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
      (ii) Documentation of the effectiveness/result of the PRN delivered.
   (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent
Living Service a MAR must be maintained at the individual’s home and an updated copy must be placed in the agency file on a weekly basis.

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

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
**Standard of Care** | **Deficiencies** | **Agency Plan of Correction, On-going QA/QI and Responsible Party** | **Date Due**
--- | --- | --- | ---

**CMS Assurance – Qualified Providers** – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

### Tag # 1A11.1
Transportation Training

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 2 of 132 Direct Support Personnel. No documented evidence was found of the following required training:</td>
<td></td>
</tr>
<tr>
<td>• Transportation (DSP #53, 157)</td>
<td></td>
</tr>
</tbody>
</table>

**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007**

**II. POLICY STATEMENTS:**

1. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:
   1. Operating a fire extinguisher
   2. Proper lifting procedures
   3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)
   4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines

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>and evacuation procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g., roadside emergency, fire emergency)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Operating wheelchair lifts (if applicable to the staff's role)</td>
</tr>
<tr>
<td>6. Wheelchair tie-down procedures (if applicable to the staff's role)</td>
</tr>
<tr>
<td>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</td>
</tr>
</tbody>
</table>
Tag # 1A20
Direct Support Personnel Training

<table>
<thead>
<tr>
<th>Tag # 1A20</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 Orientation and Training requirements were met for 12 of 132 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. 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 individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094
<table>
<thead>
<tr>
<th>Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
</tr>
<tr>
<td>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
</tr>
<tr>
<td>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</td>
</tr>
<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
</tr>
<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
</tr>
<tr>
<td>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.</td>
</tr>
<tr>
<td>Tag # A22</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
(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.

• DSP #114 stated, “No.” The Individual Specific Training section of the ISP indicates the Individual requires a Medical Emergency Response Plan for Cardiac Condition. (Individual #10)

When DSP were asked, what steps are you to take in the event of a medication error, the following was reported:

• DSP #76 stated, “Write on special sheet to report med error. Put (it) in milk carton with kitty litter and then poor Clorox over, then duck tape down milk carton; then throw (the) carton away.” (Individual #4) According to the agency’s policy for Assisting with Medication: “DSP may never discard a discontinued, contaminated or refused medication or recalled medication. Staff should place such medication in a zip lock bag or container, label it with the individual’s name, medication, time, date, staff initial, and the word contaminated. It should then be stored in the locked medication cabinet until it can be properly disposed of by an RN or the pharmacist or picked up by your service coordinator.”

• DSP #114 stated, “No.” The Individual Specific Training section of the ISP indicates the Individual requires a Medical Emergency Response Plan for Cardiac Condition. (Individual #10)
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.
### Tag # 1A25
**Criminal Caregiver History Screening**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</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 5 of 282 Agency Personnel.</td>
</tr>
</tbody>
</table>

The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:

#### Substitute Care/Respite Personnel:
- #251 – Date of hire 12/7/2007.

The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:

#### Direct Support Personnel (DSP):
- #70 – Date of hire 11/15/2003.
- #92 – Date of hire 9/1/2007.
- #110 – Date of hire 2/15/2005.

#### Substitute Care/Respite Personnel:
- #279 – Date of hire 7/25/2006.

---

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

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

---

**Provider:**
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: →

---
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>sexual contact, incest, indecent exposure, or other related felony sexual offenses;</td>
<td></td>
</tr>
<tr>
<td>E. crimes involving adult abuse, neglect or financial exploitation;</td>
<td></td>
</tr>
<tr>
<td>F. crimes involving child abuse or neglect;</td>
<td></td>
</tr>
<tr>
<td>G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</td>
<td></td>
</tr>
<tr>
<td>H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</td>
<td></td>
</tr>
</tbody>
</table>
### Tag # 1A26
**Consolidated On-line Registry Employee Abuse Registry**

**Standard Level Deficiency**

<table>
<thead>
<tr>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>

**NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:** Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.

**A. Provider requirement to inquire of registry.** A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.

- **B. Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.

**D. Documentation of inquiry to registry.** The provider shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that

Based on record review, the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 28 of 282 Agency Personnel.

**The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:**

**Substitute Care/Respite Personnel:**

- #290 – Date of hire 8/2/2011.

**Direct Support Personnel (DSP):**


**Substitute Care/Respite Personnel:**

- #179 – Date of hire 8/2/2011, completed 12/12/2011.

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

- Substitute Care/Respite Personnel:
  - #179 – Date of hire 8/2/2011, completed 12/12/2011.

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

E. **Documentation for other staff.** With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual’s current licensure as a health care professional or current certification as a nurse aide.

F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.


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

**D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider

<table>
<thead>
<tr>
<th>Employee ID</th>
<th>Date of Hire</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#196</td>
<td>10/19/2007</td>
<td>1/17/2009</td>
</tr>
<tr>
<td>#198</td>
<td>7/19/2007</td>
<td>12/19/2011</td>
</tr>
<tr>
<td>#199</td>
<td>12/10/2007</td>
<td>1/19/2009</td>
</tr>
<tr>
<td>#224</td>
<td>9/15/2007</td>
<td>4/1/2009</td>
</tr>
<tr>
<td>#228</td>
<td>5/1/2008</td>
<td>12/4/2008</td>
</tr>
<tr>
<td>#251</td>
<td>12/7/2007</td>
<td>2/13/2008</td>
</tr>
<tr>
<td>#254</td>
<td>9/1/2009</td>
<td>9/10/2009</td>
</tr>
<tr>
<td>#256</td>
<td>6/9/2008</td>
<td>6/20/2008</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Date of Hire</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>#265</td>
<td>Date of hire 6/1/2008, completed 6/19/2008.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#316</td>
<td>Date of hire 8/1/2010, completed 8/5/2010.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A28.1</td>
<td>Incident Mgt. System - Personnel Training</td>
<td>Standard Level Deficiency</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 8 of 282 Agency Personnel.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. General:</td>
<td>Direct Support Personnel (DSP):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td>• Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP # 42, 112, 123)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Training Documentation:</td>
<td>Service Coordination Personnel (SC):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</td>
<td>• Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (SC #170, 171, 172, 173)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:</td>
<td>• DSP #76 stated, &quot;DHI.&quot; Staff was not able to identify the 2nd State Agency as Adult Protective Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A37</td>
<td>Individual Specific Training</td>
<td>Standard Level Deficiency</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 2 of 134 Agency Personnel.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of personnel records found no evidence of the following: <strong>Service Coordination Personnel (SC):</strong> - Individual Specific Training (SC #172, 173)</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>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: <strong>(2) Individual-specific training</strong> for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094
(formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
**Standard of Care** | **Deficiencies** | **Agency Plan of Correction, On-going QA/QI and Responsible Party** | **Date Due**
--- | --- | --- | ---

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

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>CQI System</td>
<td>Based on record review, the Agency failed to implement their Continuous Quality Management System as required by standard.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

**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 outcomes.

Evidence found during the on-site survey and as reflected in this report of findings the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency, in addition a review of the Agency’s CQI Plan revealed the following:

- The Agency’s CQI Plan did not contain the following components:

  1. Trends in achievement of individual outcomes in the Individual Service Plans;
  2. Trends in medication and medical incidents leading to adverse health events;
  3. Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels.

**Provider:**

Enter your ongoing Quality Assurance/QI 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.
<table>
<thead>
<tr>
<th>Tag # 1A06 Policy and Procedure Requirements</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 interview, the Agency failed to ensure Agency Personnel were aware of the Agency’s On-Call Policy and Procedures for 1 of 24 Agency Personnel. When DSP were asked if the agency had an on-call procedure, the following was reported: • DSP #66 stated, “Call the other respite provider.” (Individual #66)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

B. Provider Agency Policy and Procedure Requirements: All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following:

1. Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency;

2. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and

3. Agency protocols for disaster planning and emergency preparedness.

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
<table>
<thead>
<tr>
<th>Tag # 1A09</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
</table>
| **Medication Delivery**<br>**Routine Medication Administration**<br>**Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**<br>**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.<br>**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. | Medication Administration Records (MAR) were reviewed for the months of November 2012, December 2012 and February 2013.<br>Based on record review, 7 of 24 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:<br>**Individual #4<br>February 2013**<br>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:<br>• Multivitamin Tablet (1 time daily) – Blank 2/24 (3:30PM)<br>• Omeprazole 20mg (1 time daily) – Blank 2/24 (9:30 PM)<br>• Oxybutryin 5mg (3 times daily) – Blank 2/24 (8AM); 2/6-2/24 (3:30 PM); 2/6-2/24 (9:30PM)<br><br>**Individual #9<br>February 2013**<br>As indicated by the Medication Administration Records the individual is to take Baclofen 10mg (1 time daily). According to the prescription bottle, the individual is to take Baclofen 10mg 3 times daily. Medication Administration Record and the prescription bottle do not match. **Note:** Review of the Physician’s Orders found the MAR to be correct and Individual #9 was taking the correct dosage. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: →<br>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

---


Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094

Page 40 of 72
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:

| Individual #12 |
| November 2012 |
| Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
  - Polyethylene Glycol 3350 17G (2 times daily) – Blank 11/30 (8PM) |

| Individual #17 |
| February 2013 |
| Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
  - Duvalproex Sodium 500mg (1 time daily) – Blank 2/25 |
  - Ducosate 100mg (1 time daily) – Blank 2/25 |
  - Risperidone 1mg (2 times daily) – Blank 2/25 |

| Individual #18 |
| November 2012 |
| During on-site survey Medication Administration Records were requested for months of November and December 2012. As of 2/28/2013, Medication Administration Records for November had not been provided. |

| Individual #22 |
| November 2012 |
| Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
  - Fexofenadine 180mg (1 time daily) |

Physician’s Orders indicated the following medication were to be given. The following Medications were not documented on the
(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.

Medication Administration Records:
- Ibuprofen 600mg (3 times daily)

December 2012
Physician’s Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:
- Ibuprofen 600mg (3 times daily)

February 2013
Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications:
- Fexofenadine 180mg (1 time daily)

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Atenolol 100mg (1 time daily) – Blank 2/26 (8AM)
  - Fexofenadine 180mg (1 time daily) – Blank 2/26 (7AM)
  - Hydrochlorothiazide and Valorton 40mg (1 time daily) – Blank 2/26 (8AM)
  - Spironolactone 50mg (1 time daily) – Blank 2/26 (8AM)

Individual #23
November 2012
Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:
- Blood Sugar Level (1 time daily)
<table>
<thead>
<tr>
<th>Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Blood Sugar Level (1 time daily)</td>
</tr>
<tr>
<td>Tag # 1A09.1</td>
</tr>
<tr>
<td>--------------</td>
</tr>
</tbody>
</table>
| **Medication Delivery**  
PRN Medication Administration | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Medication Administration Records (MAR) were reviewed for the months of November 2012, December 2012 and February 2013. | Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: → | |
| **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.  
**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 | Based on record review, 3 of 24 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:  
**Individual #7**  
November 2012  
Medication Administration Records did not contain the exact amount to be used in a 24 hour period:  
- Acetaminophen 325mg (PRN)  
December 2012  
Medication Administration Records did not contain the exact amount to be used in a 24 hour period:  
- Acetaminophen 325mg (PRN)  
**Individual #10**  
November 2012  
Medication Administration Records did not contain the exact amount to be used in a 24 hour period:  
- Aripiprazole 2mg (PRN)  
  - Lorazepam .50mg (PRN)  
  - Zolpidem 5mg (PRN)  
December 2012  
Medication Administration Records did not contain the exact amount to be used in a 24 hour period:  
- Aripiprazole 2mg (PRN)  
  - Lorazepam .50mg (PRN)  
  - Zolpidem 5mg (PRN) | Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
and dates of administration;
(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 administering 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.

| Individual #18 |
| November 2012 |

During on-site survey Medication Administration Records were requested for months of November and December 2012. As of 2/28/2012, Medication Administration Records for November had not been provided.

| hour period: |
| Aripiprazole 2mg (PRN) |
| Lorazepam .50mg (PRN) |
| Zolpidem 5mg (PRN) |
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.).
<table>
<thead>
<tr>
<th>Tag # 1A11</th>
<th>Transportation Policy and Procedure</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation Policy and Procedure</strong></td>
<td>Based on record review, the Agency failed to have a written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals. Review of Agency’s policies and procedures indicated the following elements were not found: (1) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (2) Vehicle maintenance and safety inspections, (3) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (4) Emergency Plans, including vehicle evacuation techniques</td>
<td><strong>State your Plan of Correction for the deficiencies cited in this tag here:</strong> →</td>
<td><strong>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</strong> →</td>
</tr>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td><strong>CHAPTER I II. PROVIDER AGENCY REQUIREMENTS:</strong> 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. <strong>G. Transportation:</strong> Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled “Client Transportation Safety”. The policy and procedures must address at least the following topics: (1) Drivers’ requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
evacuation techniques, 
(6) Documentation, and 
(7) Accident Procedures.

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy

Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007

II. POLICY STATEMENTS:

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 services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff’s role)
6. Wheelchair tie-down procedures (if applicable to the staff’s role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A27 Incident Mgt. Late and Failure to Report</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: A. Duty To Report: (1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. (2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include: (a) an environmental hazardous condition, which creates an immediate threat to life or health; or (b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. (3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and 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 25 individuals. Individual #25 • Incident date 5/16/2012. Allegation was Neglect and Exploitation. Incident report was received 6/8/2012. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.” Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
### Tag # 1A27.2
**Duty to Report**
IRs Filed During On-Site and/or
IRs Not Reported by Provider

#### 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

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, 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 24 Individuals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the on-site survey February 25 - 28, 2012, surveyors observed the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveyor’s found medical documentation indicating an individual was taken to the Emergency Room on 12/11/2012 for a shin contusion at 9:45pm. The agency had not submitted an Incident Report for this incident.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a result of what was observed Surveyors reported the following incident:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual #14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A State Incident Report regarding Emergency Services was filed on 2/27/2013 at 5:08pm.</td>
<td></td>
<td></td>
<td></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: →

---


Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094
to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division’s website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.

(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.
### Tag # 1A31
Client Rights/Human Rights

#### 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. A service provider shall not restrict or limit a client's rights except:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>
| (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or | [
| (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or | [
| (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].              | ]
| B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. | [ ]
| C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] | [ ]

**Long Term Services Division**  
**Policy Title:** Human Rights Committee

Based on record review and interview, the Agency failed to ensure the rights of Individuals was not restricted or limited for 2 of 24 Individuals.

A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#18, 21)

No documentation was found regarding Human Rights Approval for the following:

- Physical Restraint (Individual #18, 21)
- Door Chime (Individual #18)
- Room Checks (Individual #18)
- Stored Sharps (Individual #21)

When #175 was asked if the Agency had documentation of Human Rights approval, the following was reported,

- #175 stated, “We did not review them quarterly.”

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:
- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS
Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least
five years from the completion of each individual’s Individual Service Plan.

**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:**

**Medication Assessment and Delivery**

**Procedure Eff Date:** November 1, 2006

**B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency’s Human Rights Committee (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).
<table>
<thead>
<tr>
<th>Tag #1A39</th>
<th>Assistive Technology and Adaptive Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</strong></td>
<td></td>
</tr>
<tr>
<td>F. Sanitation:</td>
<td>(1) Equipment and utensils shall be kept clean and in good repair; and</td>
</tr>
<tr>
<td><strong>7.26.5.13 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - ASSESSMENTS:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS:</strong> Each ISP shall contain:</td>
<td></td>
</tr>
<tr>
<td>F. Assistive technology:</td>
<td>Necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment when a need has been identified shall be documented in the ISP. The rationale shall include the environments and situations in which assistive technology is used. Selection of assistive technology shall support the individual's independence and functional capabilities in as non-intrusive a fashion as possible.</td>
</tr>
<tr>
<td><strong>CHAPTER 5 VI. SCOPE OF SUPPORTED EMPLOYMENT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>(7) Facilitating job accommodations and use of assistive technology, including the use of communication devices;</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, observation and interview the Agency failed to ensure the necessary support mechanisms and devices, including the rationale for the use of assistive technology or adaptive equipment as in place for 1 of 24 Individuals.</td>
</tr>
<tr>
<td>Review of agency documents indicated a “hip talker” was required to be used by the Individual.</td>
</tr>
<tr>
<td><strong>During observation of the Individuals environment no evidence of item was found.</strong></td>
</tr>
<tr>
<td>• When DSP #122 was asked for the item the following was reported, “I don’t know where I put it.” (Individual #12)</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: |
### D. Provider Agency Requirements

(6) Qualification and Competencies for Supported Employment Staff (includes intensive): Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, be able to:

#### CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS

F. Community Access Services Provider Agency Staff Qualifications and Competencies

(1) Qualifications and Competencies for Community Access Coaches. The Community Access Coach shall, at a minimum, demonstrate the ability to:

(q) Communicate effectively with the individual including communication through the use of adaptive equipment and use of a communication dictionary when the individual uses these modes of communication;

(j) Communicate effectively with the individual including communication through the use of adaptive equipment as well as the individual’s Communication Dictionary, if applicable, at the work site;

#### 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:

(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 maintenance supports, as well as monitoring the effectiveness of such supports;

(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;

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

#### H. Community Living Services Provider Agency Staffing Requirements

(1) Community Living Service Staff Qualifications and Competencies: Individuals working as direct support staff and supervisors for Community Living Service Provider Agencies shall demonstrate the following:

(b) The ability to assist the individual to meet his or her physical (e.g., health, grooming, toileting, eating) and personal management needs, by teaching skills, providing supports, and building on individual strengths and capabilities;

#### 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:
(5) Kitchen area shall:
(b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and
| Tag # 6L06  
Family Living Requirements | Standard Level Deficiency | Provider: |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to complete all DDSD requirements for approval of each direct support provider for 1 of 21 individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here:</td>
</tr>
</tbody>
</table>
|                             | • Monthly Consultation with the Direct Support Provider  
   o Individual #10 - None found for 6/2012. | →|
| A. Support to Individuals in Family Living: The Family Living Services Provider Agency shall provide and document: | Provider: |
| (5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include: | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: |
|   (a) Review, advise, and prompt the implementation of the individual’s ISP Action Plans, schedule of activities and appointments; and | →|
|   (b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members. | ]|
Developmental Disabilities (DD) Waiver
Service Standards effective 4/1/2007

CHAPTER 1. I. PROVIDER AGENCY
ENROLLMENT PROCESS
D. Scope of DDSD Agreement

(4) Provider Agencies must have prior written
approval of the Department of Health to
subcontract any service other than
Respite;

NMAC 8.314.5.10 - DEVELOPMENTAL
DISABILITIES HOME AND COMMUNITY-
BASED SERVICES WAIVER

ELIGIBLE PROVIDERS:
I. Qualifications for community living
service providers: There are three types of
community
living services: Family living, supported living
and independent living. Community living
providers must meet all qualifications set forth
by the DOH/DDSD, DDW definitions and
service standards.
(1) Family living service providers for adults
must meet the qualifications for staff required
by the
DOH/DDSD, DDW service definitions and
standards. The direct care provider employed
by or subcontracting with the provider agency
must be approved through a home study
completed prior to provision of services and
conducted
at subsequent intervals required of the provider
agency. All family living sub-contracts must be
approved by the DOH/DDSD.
| Tag # 6L13  
Community Living Healthcare Reqts. | Standard Level Deficiency |  |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 6 of 24 individuals receiving Community Living Services.</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING G. Health Care Requirements for Community Living Services.</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual’s health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual’s HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Provision of health care oversight consistent with these Standards as</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: →

---


Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094
detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.

c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.

(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.

(5) That the physical property and grounds are free of hazards to the individual’s health and safety.

(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:

(a) The individual has a primary licensed physician;

(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;

(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;

(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and

(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in

follow-up found.

- **Blood Levels**
  - Individual #6 - As indicated by collateral documentation reviewed, lab work was ordered on 11/30/2012. No evidence of lab results were found.

- **Occult Blood Series Stool Test**
  - Individual #7 - As indicated by collateral documentation reviewed, the testing was ordered on 7/6/2012. No evidence of testing results was found.
medication or daily routine).

**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

**B. Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 6L25</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residential Health and Safety (SL/FL)</strong></td>
<td>Based on observation, the Agency failed to ensure that each individual’s residence met all requirements within the standard for 6 of 21 Family Living residences.</td>
</tr>
</tbody>
</table>

Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:

**Family Living Requirements:**

- Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#7)
- 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 (#9, 10, 13, 15, 17)

<table>
<thead>
<tr>
<th>Provider:</th>
<th>State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>

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


Survey Report #: Q.13.3.DDW.A0413.2/5.001.RTN.01.094
unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability</strong> – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</td>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 21 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td><strong>Tag # 6L27 Family Living Reimbursement</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- The Agency billed 16 units of Family Living (T2033) from 10/1/2012 through 10/16/2012. Documentation received accounted for 13 units. Documentation did not contain the required elements on 10/1, 2 and 3. One or more of the following elements was not met:  
  ➢ A description of what occurred during the encounter or service interval. Note: Documentation for each date listed above indicated “subcare.” Documentation did not indicate when FL services began or ended. | | |
| **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** | November 2012  
- The Agency billed 12 units of Family Living (T2033) from 11/1/2012 through 11/12/2012. Documentation received accounted for 8 units. Documentation did not contain the required elements on 11/1, 2, 3 and 4. One or more of the following elements was not met:  
  ➢ A description of what occurred during the encounter or service interval. Note: Documentation for each date listed above indicated “subcare.” | | |
| **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: | | | |
Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

B. Reimbursement for Family Living Services

(1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.

(2) Billable Activities shall include:
   (a) Direct support provided to an individual in the residence any portion of the day;
   (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
   (c) Any other activities provided in accordance with the Scope of Services.

(3) Non-Billable Activities shall include:
   (a) The Family Living Services Provider Agency may not bill for room and board;
   (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
   (c) Family Living services may not be billed for the same time period as

Documentation did not indicate when FL services began or ended.

December 2012

- The Agency billed 10 units of Family Living (T2033) from 12/1/2012 through 12/10/2012. Documentation received accounted for 7 units.
- Documentation did not contain the required elements on 12/1, 2 and 3. One or more of the following elements was not met:
  - A description of what occurred during the encounter or service interval. Note: Documentation for each date listed above indicated “subcare.”
  - Documentation did not indicate when FL services began or ended.

Individual #14

November 2012

- The Agency billed 29 units of Family Living (T2033) from 11/1/2012 through 11/29/2012. Documentation did not contain the required elements on 11/17. Documentation received accounted for 28 units. One or more of the following elements was not met:
  - A description of what occurred during the encounter or service interval

December 2012

- The Agency billed 29 units of Family Living (T2033) from 12/1/2012 through 12/29/2012. Documentation did not contain the required elements on 12/15, 19, 21, 22 and 24. Documentation received accounted for 24 units. One or more of the following elements was not met:
  - A description of what occurred during the encounter or service interval
Respite.
(d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 -
Chapter 6 - COMMUNITY LIVING SERVICES III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES
C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 -
DEFINITIONS
SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.
Date: June 10, 2013

To: Carol Lynn Herrera, Executive Director
Provider: Expressions of Life, Inc.
Address: 9151 High Assets Way
State/Zip: Albuquerque, New Mexico 87120

E-mail Address: xpreslife@qwestoffice.net

Region: Metro and Northeast
Survey Date: February 25 - 28, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Family Living and Independent Living)
Survey Type: Routine

Dear Ms. Herrera;

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