Dear Ms. McGlasson;

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:

**Partial Compliance with Conditions of Participation**

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

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

Entrance Conference Date: January 14, 2013

Present: Goodwill Industries of New Mexico
Valerie McGlasson, Workforce Director
Bradly Brane, Workforce Employment Programs Coordinator

DOH/DHI/QMB
Jennifer Bruns, BSW, Team Lead/Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor
Meg Pell, BA, Healthcare Surveyor

Exit Conference Date: January 17, 2013

Present: Goodwill Industries of New Mexico
Mary Best, President/CEO
Valerie McGlasson, Workforce Director
Bradly Brane, Workforce Employment Programs Coordinator
Elaine Kapuscinski, Transitional Opportunity Program Manager

DOH/DHI/QMB
Jennifer Bruns, BSW, Team Lead/Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor
Meg Pell, BA, Healthcare Surveyor

Administrative Locations Visited Number: 3:
- 5000 San Mateo Blvd. NE, Albuquerque, New Mexico
- 3211 Coors Blvd. SW, Albuquerque, New Mexico
- 2003 Southern Blvd SE, Rio Rancho, New Mexico

Total Sample Size Number: 10
- 0 - Jackson Class Members
- 10 - Non-Jackson Class Members
- 10 - Supported Employment

Persons Served Records Reviewed Number: 10

Persons Served Interviewed Number: 5

Persons Served Observed Number: 5 (5 individuals were working at the time of the on-site survey)

Direct Support Personnel Interviewed Number: 8 (Note: 2 Agency personnel interviewed had dual roles as Direct Support Personnel/Service Coordinators).

Direct Support Personnel Records Reviewed Number: 6

Service Coordinator Records Reviewed Number: 8

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

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

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

The Plan of Correction must address the required six CMS core elements to address each deficiency of the POC:

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

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

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

The following details should be considered when developing your POC:

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
   a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

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

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

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

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.
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 the provider’s compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**CMS Assurance – Service Plans: ISP Implementation** – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Agency Case File</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A08</td>
<td>Agency Case File</td>
<td>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 10 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Annual ISP</td>
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<tr>
<td></td>
<td></td>
<td>° Not Found (#1 &amp; 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ISP Signature Page (#1 &amp; 6)</td>
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<tr>
<td></td>
<td></td>
<td>• Individual Specific Training Section of ISP (formerly Addendum B) (#1 &amp; 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ISP Teaching and Support Strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>° Individual #2 - TASS not found for the following Action Steps:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ Work/Learn Outcome Statement: “...will work in the store inside Goodwill Industries of New Mexico 2 days a week 9 - 3 during 12 - 13 ISP Year.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>➢ “…will avoid absences from work or changes in work vacation.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Positive Behavioral Plan (#1, 6 &amp; 8)</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: →
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:

- Positive Behavioral Crisis Plan (#1, 6 & 8)
- Speech Therapy Plan (#5)
- Occupational Therapy Plan (#1)
- Physical Therapy Plan (#1)
- Annual Physical (#1, 2, 4, & 6)
- Dental Exam
  - Individual #1 - As indicated by collateral documentation reviewed, the exam was completed on 4/29/2011. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.
  - Individual #2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
  - Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 4/26/2011. Per ISP Health and Safety Section follow-up is to occur every 6 months. No evidence of follow-up found.
  - Individual #6 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.

- Vision Exam
  - Individual #2 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
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.

| Individual #4 | As indicated by collateral documentation reviewed, the exam was completed on 10/09/2008. As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of current exam was found. |
| Individual #6 | As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. |

- **Auditory Exam**
  - Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 11/04/2008. Follow-up was to be completed in two years. No evidence of follow-up found.
Tag # 1A32 & 6L14 ISP Implementation

<table>
<thead>
<tr>
<th>Tag # 1A32 &amp; 6L14 ISP Implementation</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>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 10 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td>→</td>
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<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
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<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td></td>
<td></td>
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<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 2 of 10 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
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<td>Administrative Files Reviewed:</td>
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<tr>
<td>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
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<tr>
<td>Individual #1</td>
<td>None found for 9/2012 - 11/2012. No ISP was found in individual records.</td>
<td></td>
</tr>
<tr>
<td>Individual #6</td>
<td>None found for 9/2012 - 11/2012. No ISP was found in individual records.</td>
<td></td>
</tr>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</tbody>
</table>
play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.

[05/03/94; 01/15/97; Recompiled 10/31/01]
<table>
<thead>
<tr>
<th>Tag # 5111 Reporting Requirements (Community Inclusion Quarterly Reports)</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual’s Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:
   (1) Identification and implementation of a meaningful day definition for each person served;
   (2) Documentation summarizing the following:
      (a) Daily choice-based options; and
      (b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.
   (3) Significant changes in the individual's routine or staffing;
   (4) Unusual or significant life events;
   (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;
   (6) Record of personally meaningful community inclusion;
   (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and
   (8) Any additional reporting required by DDSD. | Based on record review, the Agency failed to complete quarterly reports as required for 4 of 10 individuals receiving Community Inclusion services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: **Supported Employment Quarterly Reports**
   - Individual #1 - None found for 2/2012 - 9/2012.
   - Individual #2 - None found for 2/2012 - 11/2012.
   - Individual #6 – None found for 9/2012 - 11/2012.
   - Individual #9 – None found for 6/2012 - 11/2012. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: →
Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

Survey Report #: Q.13.3.DDW.D0471.5.001.RTN.01.028
<table>
<thead>
<tr>
<th>Tag # 5122 SE Agency Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 10 individuals receiving Supported Employment Services. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
  - Required Certificates & Documentation  
    - Time study (#8) | State your Plan of Correction for the deficiencies cited in this tag here: → | |

**CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS**

**D. Provider Agency Requirements**

1. Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.

2. The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:

   a. Quarterly progress reports;
   b. Vocational assessments (A vocational assessment or profile is an objective analysis of a person’s interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;
   c. Career development plan as incorporated in the ISP; a career development plan consists of...
the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy
Policy Title: Vocational Assessment Profile Policy Eff July 16, 2008
I. PURPOSE
The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.

II. POLICY STATEMENT
Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.
### 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.

<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 6 Direct Support Personnel. | **Provider:**
State your Plan of Correction for the deficiencies cited in this tag here: → | | |

**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

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

- Person-Centered Planning (1-Day) (DSP #43)
- First Aid (DSP #43 & 45)
- CPR (DSP #42 & 43)

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.

**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy**  
- **Policy Title:** Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007  
- **II. POLICY STATEMENTS:**
  
  A. Individuals shall receive services from competent and qualified staff.  
  B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.  
  C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.  
  D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.  
  E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.  
  F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.  
  G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.  
  H. Staff shall complete and maintain certification in a DDSD-approved medication course in
accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
Tag # 1A22  Agency Personnel Competency


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.

F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:

(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;

(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;

(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the

<table>
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<tr>
<th>Condition of Participation Level Deficiency</th>
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<tr>
<td>After an analysis of the evidence, including a significant number of missing Healthcare Plans and Medical Emergency Response Plans, staff competency issues and lack of functioning Quality Assurance Plan, it has been determined there is a significant potential for a negative outcome to occur.</td>
</tr>
<tr>
<td>Based on interview, the Agency failed to ensure that training competencies were met for 3 of 6 Direct Support Personnel.</td>
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</tbody>
</table>

When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:
- DSP #42 stated, "I don't know. I haven't met the OT." According to collateral documentation reviewed, the Individual requires an Occupational Therapy Plan. (Individual #6)

When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:
- DSP #43 stated, "I haven't seen anything like that." As indicated by the Individual Specific Training section of the ISP the Individual requires Health Care Plans for Weight/Body Mass Index, Diabetes & Respiratory. (Individual #2)
- DSP #44 stated, "Not as far as I know." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index, Neuro device implant, Seizures,

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

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

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

Department of Health (DOH) Developmental

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Constipation & Pain. (Individual #3)

When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:

- DSP #43 stated, “I haven’t seen anything like that.” As indicated by the Individual Specific Training section of the ISP indicates the Individual requires Medical Response Plans for Gastrointestinal, Asthma, Diabetes, & Pain. (Individual #2)

- DSP #44 stated, “Not as far as I know.” As indicated by the Electronic Comprehensive Health Assessment Tool and the Individual Specific Training section of the ISP, the Individual requires Medical Emergency Response Plans for Seizures, Diabetes, Pain, & Neuro device implant. (Individual #3)
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.
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td>Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 3 of 8 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td>Service Coordination Personnel (SC): • Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers' Property) (#48, 49 &amp; 50)</td>
<td></td>
</tr>
<tr>
<td>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</td>
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<tr>
<td>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</td>
<td>II. POLICY STATEMENTS: A. Individuals shall receive services from</td>
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</table>
competent and qualified staff.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 1A36 Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 8 Service Coordinators.</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 Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</td>
<td></td>
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<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:</td>
<td>• Person Centered Planning (2-Day) (SC #47 &amp; 51)</td>
<td></td>
</tr>
<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
<td>• Promoting Effective Teamwork (SC #47 &amp; 51)</td>
<td></td>
</tr>
<tr>
<td>NMAC 7.26.5.7 “service coordinator”: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the</td>
<td>• ISP Critique (SC #46)</td>
<td></td>
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<td></td>
<td>• Sexuality for People with Developmental Disabilities (SC #46)</td>
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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: →


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

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
Tag # 1A37 Individual Specific Training

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 3 of 8 Agency Personnel.</td>
</tr>
<tr>
<td>Review of personnel records found no evidence of the following:</td>
</tr>
<tr>
<td>Service Coordination Personnel (SC):</td>
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<tr>
<td>- Individual Specific Training (#49, 50 &amp; 51)</td>
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</table>

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

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

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Survey Report #: Q.13.3.DDW.D0471.5.001.RTN.01.028
specifications described in the individual service plan (ISP) of each individual served.
### CMS Assurance – Health and Welfare

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

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| 1A03   | Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency has not fully implemented the Continuous Quality Management System as required by standard. Review of the Agency’s CQI Plan revealed the following: 1) The Agency’s Continuous Quality Improvement Plan provided during the on-site survey (January 14 - 17, 2013) was not dated. No evidence was found indicating when the document had been created, updated or last reviewed. 2) Review of the findings identified during the routine 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. | Provider:
State your Plan of Correction for the deficiencies cited in this tag 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:

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<td>(1)</td>
<td>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;</td>
</tr>
<tr>
<td>(2)</td>
<td>community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;</td>
</tr>
<tr>
<td>(4)</td>
<td>community based service providers</td>
</tr>
</tbody>
</table>
providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A15 Healthcare Documentation - Nurse Contract/Employee</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6 VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS K. Nursing Requirements and Roles (1) All Community Living Service Provider Agencies are required to have a registered nurse (RN) on staff. The agency nurse may be an employee or a sub-contractor. (3) A Community Living Support Provider Agency shall not use a licensed practical nurse (LPN) without a registered nurse (RN) supervisor.</td>
<td>After an analysis of the evidence, including a significant number of missing Healthcare Plans and Medical Emergency Response Plans, staff competency issues and lack of functioning Quality Assurance Plan, it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency failed to provide an employed or contracted licensed registered nurse. Review of Agency records found no evidence of an employed or contracted nurse. When the Director (#54) was asked if the Agency had an employed or contracted licensed registered nurse, the following was reported: • Director (#54) stated, “We currently don’t have a Nurse. We hired someone but they never started.” The Director went on to say “we are working with DDSD to see if they can give us some names.” When the Director (#54) was asked how long the Agency had been without a licensed nurse, Agency Director (#54) did not supply the information to the Survey Team. Several verbal and written attempts were made by the Survey Team to get this information from #54, including at the exit conference. As of 1/28/2013 this information has not been provided.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
<table>
<thead>
<tr>
<th>Tag # 1A15.1 Nurse Availability</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| **Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**  
**Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**  
E. Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.  
**NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3**  
I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:  
(1) contributing to the assessment of the health status of individuals, families and communities;  
(2) participating in the development and modification of the plan of care;  
(3) implementing appropriate aspects of the plan of care commensurate with education and verified competence;  
(4) collaborating with other health care professionals in the management of health care; and  
(5) participating in the evaluation of responses to interventions  
**After an analysis of the evidence, including a significant number of missing Healthcare Plans and Medical Emergency Response Plans, staff competency issues and lack of functioning Quality Assurance Plan, it has been determined there is a significant potential for a negative outcome to occur.**  
Based on interview, the Agency failed to ensure nursing services were available as needed for 4 of 10 individuals.  
**When Direct Service Professionals (DSP) were asked about the availability of their agency nurse, the following was reported:**  
- DSP #42 stated, "Not that I am aware of."
- DSP #43 stated, "There’s no nurse here."
- DSP #52 stated, "No."

(Note: DSP #43 interviewed for 2 different Individuals receiving services). | State your Plan of Correction for the deficiencies cited in this tag here: → | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
**Tag # 1A15.2 & 5I09 - Healthcare Documentation**

<table>
<thead>
<tr>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>After an analysis of the evidence, including a significant number of missing Healthcare Plans and Medical Emergency Response Plans, staff competency issues and lack of functioning Quality Assurance Plan, it has been determined there is a significant potential for a negative outcome to occur.</td>
<td></td>
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<tr>
<td>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 5 of 10 individual</td>
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<tr>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
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<tr>
<td>• Electronic Comprehensive Health Assessment Tool (eChat) (#2, 6 &amp; 8)</td>
<td></td>
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<tr>
<td>• Medication Administration Assessment Tool (#1, 2, 4, 6 &amp; 8)</td>
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<tr>
<td>• Healthcare Passport (#1, 2 &amp; 8)</td>
<td></td>
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<tr>
<td>• Aspiration Risk Management Screening Tool (#1, 2, 4, 6 &amp; 8)</td>
<td></td>
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<tr>
<td>• <strong>Special Health Care Needs:</strong></td>
<td></td>
</tr>
<tr>
<td>• <em>Nutritional/Dietary Plan</em></td>
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<tr>
<td>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan due to lactose intolerance. No evidence of a plan found.</td>
<td></td>
</tr>
<tr>
<td>• <em>Health Care Plans</em></td>
<td></td>
</tr>
<tr>
<td>◦ Individual #1 - According to Electronic</td>
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</table>

**CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

**Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities**

(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:

(i) Community living services provider agency;
(ii) Private duty nursing provider agency;
(iii) Adult habilitation provider agency;
(iv) Community access provider agency; and
(v) Supported employment provider agency.

(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual’s Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these...
assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first.

(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy).

(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency,

<table>
<thead>
<tr>
<th>Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</th>
</tr>
</thead>
<tbody>
<tr>
<td>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
<tr>
<td>◦ Diabetes</td>
</tr>
<tr>
<td>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
<tr>
<td>◦ Neuro device/implant</td>
</tr>
<tr>
<td>◦ Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
<tr>
<td>◦ Pain</td>
</tr>
<tr>
<td>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
<tr>
<td>◦ Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
<tr>
<td>◦ Respiratory</td>
</tr>
<tr>
<td>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
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<tr>
<td>◦ Seizure</td>
</tr>
<tr>
<td>◦ Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
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</table>
method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.
(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):
(a) Each healthcare plan must include a statement of the person’s healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain

- **Crisis Plans/Medical Emergency Response Plans**
  - **Allergy to Phenobarbital**
    - Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - **Asthma**
    - Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - **Cholesterol & Triglycerides**
    - Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - **Diabetes**
    - Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - **Falls**
    - Individual #8 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
  - **Gastrointestinal**
    - Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - **Neuro device/implant**
    - Individual #8 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
  - **Pain**
a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

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

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

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

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

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

(g) All crisis prevention and intervention plans and healthcare plans shall include the individual’s name and date on each page and shall be signed by the author.

○ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation
(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.
(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.


CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

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

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

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
<table>
<thead>
<tr>
<th>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</strong></td>
<td>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers’ Property, for 2 of 10 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>A. General:</strong> 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>• Parent/Guardian Incident Management Training (Abuse, Neglect &amp; Misappropriation of Consumers’ Property) (#4 &amp; 5)</td>
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<tr>
<td><strong>E. Consumer and Guardian Orientation Packet:</strong> Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer’s file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</td>
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</tbody>
</table>

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
**Tag # 5125  Supported Employment Reimbursement**

**Deficiencies**

Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 6 of 10 individuals.

**Individual #2  November 2012**
- The Agency billed 233 units of Supported Employment (T2019 U3) from 11/1/2012 through 11/30/2012. Documentation received accounted for 219 units.

**Individual #5  October 2012**
- The Agency billed 1 unit of Supported Employment (T2013) on 10/1/2012. Documentation received accounted for 0 units.

**Individual #6  September 2012**
- The Agency billed 192 units of Supported Employment (T2019 U2) from 9/1/2012 through 9/30/2012. Documentation received accounted for 168 units.

**Individual #7  September 2012**
- The Agency billed 4 units of Supported Employment (T2013) on 9/1/2012. Documentation did not contain the required elements on 9/10 & 17. Documentation received accounted for 0 units. One or

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

**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: →
provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS

E. Reimbursement

(1) Billable Unit:

(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.

(b) The billable unit for Individual Supported Employment is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less than one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:

(i) Researching potential employers via telephone, Internet, or visits;
(ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;
(iii) Arranging appointments for job tours, interviews, and job trials;
(iv) Documenting job search and more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval.

(Note: As indicated by documents reviewed the Agency billed T2013 services on 9/1/2012 which was prior to services being delivered.)

Individual #8
November 2012
- The Agency billed 225 units of Supported Employment (T2019 U1) from 11/1/2012 through 11/30/2012. Documentation received accounted for 213 units.

Individual #9
September 2012
- The Agency billed 292 units of Supported Employment (T2019 U1) 9/1/2012 through 9/30/2012. Documentation did not contain the required elements on 9/3. Documentation received accounted for 274 units. One or more of the following elements was not met:

- The signature or authenticated name of staff providing the service.
(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and
(vi) Meetings with individual surrounding job development or retention not at the employer's site.
(c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.
(d) Group Supported Employment is a fifteen-minute unit.
(e) Self-employment is a fifteen minute unit.

4. Billable Activities include:
(a) Activities conducted within the scope of services;
(b) Job development and related activities for up to ninety (90) calendar days that result in employment of the individual for at least thirty (30) calendar days; and
(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office.
Dear Ms. McGlasson;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the Routine Survey on January 14 – 17, 2013.

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

**Compliance with Conditions of Participation**

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

Sincerely,

**Jennifer Bruns, BSW**

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

Entrance Conference Date: May 9, 2013

Present:

**Goodwill Industries of New Mexico**
Valerie McGlasson, Workforce Director
Bradly Brane, Workforce Employment Programs Coordinator

**DOH/DHI/QMB**
Jennifer Bruns, BSW, Team Lead/Healthcare Surveyor
Meg Pell, BA, Healthcare Surveyor

Exit Conference Date: May 9, 2013

Present:

**Goodwill Industries of New Mexico**
Valerie McGlasson, Workforce Director
Bradly Brane, Workforce Employment Programs Coordinator
Katrina Sloan, Transitional Opportunity Program Manager

**DOH/DHI/QMB**
Jennifer Bruns, BSW, Team Lead/Healthcare Surveyor
Meg Pell, BA, Healthcare Surveyor

Administrative Locations Visited Number: 1

Total Sample Size Number: 10

- 0 - Jackson Class Members
- 10 - Non-Jackson Class Members
- 10 - Supported Employment

Persons Served Records Reviewed Number: 5

Direct Support Personnel Interviewed Number: 6 *(Note: 3 Agency personnel interviewed had dual roles as Direct Support Personnel/Service Coordinators).*

Direct Support Personnel Records Reviewed Number: 9

Service Coordinator Records Reviewed Number: 4

Administrative Processes and Records Reviewed:

- 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
• 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
DOH - Internal Review Committee
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 the provider’s compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

**Service Domain: Level of Care**
Condition of Participation:
5. **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:
6. **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:
7. **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:
8. **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:
6. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

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

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

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

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

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

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

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.
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:
5. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief within 10 business days of receipt of the final Report of Findings.
6. 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
7. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
8. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status. If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
**Agency:** Goodwill Industries of New Mexico - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Inclusion Supports (Supported Employment)  
**Monitoring Type:** Verification Survey  
**Routine Survey:** January 14 - 17, 2013  
**Verification Survey:** May 9, 2013

|------------------|-----------------------------------------------|---------------------------------------------|

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

**Tag # 1A15.1 Nurse Availability**

<table>
<thead>
<tr>
<th>Condition of Participation Level Deficiency</th>
<th>Standard Level Deficiency</th>
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| After an analysis of the evidence, including a significant number of missing Healthcare Plans and Medical Emergency Response Plans, staff competency issues and lack of functioning Quality Assurance Plan, it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency failed to ensure nursing services were available as needed for 4 of 10 individuals. When Direct Service Professionals (DSP) were asked about the availability of their agency nurse, the following was reported:  
   - DSP #42 stated, “Not that I am aware of.”  
   - DSP #43 stated, “There’s no nurse here.”  
   - DSP #52 stated, “No.” (Note: DSP #43 interviewed for 2 different individuals receiving services). | New/Repeat Finding: Based on Interview, the Agency did not provide nursing services as required by standards. When Surveyors asked for written verification regarding the on-call nurse training the Agency provided a document indicating staff with previous deficiencies (#42, 43, and 52) were trained. Yet review of the document did not provide clear evidence of what was discussed during the training or an agenda. A written statement provided by #60 stated, the following:  
   - Agency Provided written statement, by #60 stating, “Program Manager on March 15, 2013 conducted a training on Goodwill Industries of New Mexico’s on call nurse for #42, 43 and 52 that at this time Goodwill in working on a finding a nurse. The status of the on call nurse and her duties/function at GINM: Conduct MERP training, Healthcare plans, Aspiration Risk Training, New Medication side effects, and General concerns. The nurse will be contacted by the Program.” |

NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3

1. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:
(1) contributing to the assessment of the health status of individuals, families and communities; 
(2) participating in the development and modification of the plan of care; 
(3) implementing appropriate aspects of the plan of care commensurate with education and verified competence; 
(4) collaborating with other health care professionals in the management of health care; and 
(5) participating in the evaluation of responses to interventions.

Manager of concerns as they arise, so that she may be contacted. Once a nurse is hired they would be informed and introduced. "

Nevertheless, at the time of the verification survey the Agency still did not have a staff or contract nurse available to Individuals receiving service. If nursing services were required during work hours a nurse from the individual’s primary provider agency would need to serve this purpose.
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<tbody>
<tr>
<td><strong>Service Domain: Service Plans: ISP Implementation</strong> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
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<tr>
<td>Tag # 1A08 Agency Case File</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>Tag # 1A32 &amp; 6L14 ISP Implementation</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 5I22 SE Agency Case File</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Service Domain: Qualified Providers</strong> – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A20 Direct Support Personnel Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A22 Agency Personnel Competency</td>
<td>Condition of Participation Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A28.1 Incident Mgt. System - Personnel Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A36 Service Coordination Requirements</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A37 Individual Specific Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>Service Domain: Health and Welfare</strong> – 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A03 CQI System</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A15 Healthcare Documentation - Nurse Contract/Employee</td>
<td>Condition of Participation Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A15.2 &amp; 5I09 - Healthcare Documentation</td>
<td>Condition of Participation Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Service Domain: 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></td>
<td></td>
</tr>
<tr>
<td>Tag # 5I25   Supported Employment Reimbursement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
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<td>-----------</td>
</tr>
</tbody>
</table>
Date:    November 26, 2013

To:    Valerie McGlasson, Workforce Director

Provider:    Goodwill Industries of New Mexico

Address:    5000 San Mateo Blvd. NE

State/Zip:    Albuquerque, New Mexico 87109

E-mail Address:    vmcglasson@goodwillnm.org

CC:    Mary Best, President/CEO

E-Mail Address    mbest@goodwillnm.org

Region:    Metro

Routine Survey:    January 14 - 17, 2013

Verification Survey:    May 9, 2013

Program Surveyed:    Developmental Disabilities Waiver

Service Surveyed:    Community Inclusion Supports (Supported Employment)

Survey Type:    Verification

Dear Ms. McGlasson;

According to the IRC Letter dated November 5, 2013, your agency, Goodwill Industries of New Mexico, has completed all the requirements per the Internal Review Committee (IRC).

The Plan of Correction process for the above mentioned surveys is now complete.

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

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

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

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

Sincerely,

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

Q.14.2-DDW.D0471.5.001.RTN.09.330