Date:	December 7, 2012
To:	Cruz Rojas, Executive Director
Provider:	Grace Requires Understanding, Inc.
Address:	1100 S. Main Suite A
State/Zip:	Las Cruces, New Mexico 88005
E-mail Address:	cmrojas@mygru.org
CC:	Victor Duran, Board Chair
Address:	P. O. Box 2334
State/Zip:	Mesilla Park, NM 88047
E-Mail Address:	victord3@msn.com
Region:	Southwest
Routine Survey:	March 5 - 9, 2012
Verification Survey:	November 13 – 15, 2012
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Living Supports (Family Living & Independent Living) & Inclusion Supports (Community Access)
Survey Type:	Verification
Team Leader:	Valerie V. Valdez, M.S., Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau
Team Members:	Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Amanda Castaneda, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Rojas:

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 *March 5 - 9, 2012*, as well as your Plan of Correction regarding the IRC actions related to Individual Funds. 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.

Thank you for your cooperation and for the work you perform.

Sincerely,

Valerie V. Valdez, M.S.

Valerie V. Valdez, M.S.
Healthcare Program Manager/Team Lead
Division of Health Improvement, Quality Management Bureau

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

Survey Process Employed:

Entrance Conference Date:	November 13, 2012	
Present:	**Grace Requires Understanding, Inc.** Cruz Maria Rojas, Executive Director **DOH/DHI/QMB** Valerie V. Valdez, MS, Healthcare Program Manager Mari Chavez, BSW, Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor	
Exit Conference Date:	November 15, 2012	
Present:	**Grace Requires Understanding, Inc.** Cruz Maria Rojas, Executive Director Teresa S. Jiminez, Financial Manager Noel Marquez, Family Supports Manager Theresa Martinez, Financial Administration Assistant Yvonne Ramos, Family Supports Manager Maria C. Rubio Family Supports Manager Cassandra Ordunez, Assistant/Secretary Virginia Sanchez, Training Coordinator/Trainer Dolores Ordunez, Administrative Assistant **DOH/DHI/QMB** Valerie V. Valdez, MS, Healthcare Program Manager Mari Chavez, BSW, Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor **DDSD - SW Regional Office** Scott Doan, SW DDSD Regional Director	
Total Homes Visited	Number:	19
❖ Family Homes Visited	Number:	19
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	21 0 - *Jackson* Class Members 21 - Non-*Jackson* Class Members 19 - Family Living 2 - Independent Living 13 - Community Access
Persons Served Records Reviewed	Number:	21
Direct Support Personnel Interviewed	Number:	21
Direct Support Personnel Records Reviewed	Number:	148
Service Coordinator Records Reviewed	Number:	12 (7 Service Coordinators are also Direct Support Personnel)

Administrative Files Reviewed

- Billing Records
- Medical Records

- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

Attachment B

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

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

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

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

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

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

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

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

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

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Grace Requires Understanding, Inc - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Living Supports (Family Living & Independent Living) & Inclusion Supports (Community Access)
Survey Type: Verification
Routine Survey: **March 5 - 9, 2012**
Verification Survey: **November 13 – 15, 2012**

Standard of Care	*March 5 – 9, 2012 Deficiencies*	November 13 - 15, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32 & 6L14 ISP Implementation	***Condition of Participation Level Deficiency***	**Standard Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, 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 14 of 22 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #15 • None found for 10/2011 & 12/2011. Individual #16	**New/Repeat Finding:** Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 19 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • Review of Agency's documented Outcomes & Action Steps do not match the current ISP Outcomes and Action Steps for the Work/Education/Volunteer area.

extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	• None found for 11/2011. **Independent Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #17 • None found for 11/2011 – 1/2012. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #5 • None found for 11/2011 – 1/2012. Individual #6 • None found for 11/2011. Individual #7 • None found for 11/2011 – 1/2012. Individual #12 • None found for 11/2011 – 1/2012. Individual #13 • None found for 11/2011 – 1/2012. Individual #18 • No Outcomes or DDSD exemption/decision justification found for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." Individual #19 • None found for 11/2011 – 1/2012. Individual #21 • None found for 11/2011.	• Review of Agency's documented Outcomes & Action Steps do not match the current ISP Outcomes and Action Steps for the Develop Relationships/Have Fun area.

	Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #1 • None found for 1/2012. Individual #7 • None found for 11/2011 – 1/2012. Individual #14 • None found for 11/2011 – 12/2011. Individual #22 • No Outcomes or DDSD exemption/decision justification found for Community Access Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."	

Standard of Care	*March 5 – 9, 2012 Deficiencies*	November 13 - 15, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
CMS Assurance – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: (1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and (2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.	Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 44 of 173 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #72, 107, 127, 189 & 202) • Foundation for Health & Wellness (DSP #147 & 189) • Person-Centered Planning (1-Day) (DSP #49, 67, 72, 107, 119, 136, 159 & 189) • First Aid (DSP #50, 54, 63, 66, 88, 89, 115, 118, 131, 141, 166, 175, 176, 196, 205 & 206) • CPR (DSP #45, 50, 54, 66, 83, 88, 115, 118, 131, 148, 161, 164, 166, 170, 175, 176, 191, 196, 205 & 212) • Assisting With Medication Delivery (DSP #72, 86, 87, 107, 115, 135, 141, 175, 189 & 191) • Participatory Communication & Choice Making (DSP #80, 101, 117, 119, 141, 162 & 191) • Advocacy 101 (DSP #119, 141, 147 & 184)	**New/Repeat Finding:** Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 148 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #224)

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.	• Positive Behavior Supports Strategies (DSP #80, 119, 141, 147 & 184) • Teaching & Support Strategies (DSP #80, 119, 141, 147, 171 & 184)	

Tag # 1A26 Consolidated On-line Registry/Employee Abuse Registry	*Condition of Participation Level Deficiency*	Standard Level Deficiency
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 18 of 185 Agency Personnel. **The following Agency personnel records contained NO evidence of the Employee Abuse Registry being completed:** **Direct Support Personnel (DSP):** • #81 – Date of hire 5/20/2008. • #95 – Date of hire 1/18/2008. • #122 – Date of hire 3/11/2005. • #132 – Date of hire 12/2/2004. • #140 – Date of hire 10/16/2006. • #147 – Date of Hire 12/15/2009. • #201 – Date of hire 9/25/2008. • #210 – Date of hire 9/7/2007. **Service Coordination Personnel (SC):** • #214 – Date of hire 7/18/2011. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:** **Direct Support Personnel (DSP):** • #84 – Date of hire 9/1/2007, completed	**New/Repeat Finding:** Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 1 of 169 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:** **Direct Support Personnel (DSP):** • #223 – Date of hire 6/12/2009. Note: Staff #223 was working with the agency at the time of the original routine survey but the agency omitted the name from the list requested.

respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1.IV. General Provider Requirements.** **D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.	3/7/2012. • #89 – Date of hire 1/1/2010, completed 3/31/2010. • #120 – Date of hire 4/25/2011, completed 5/5/2011. • #127 – Date of hire 10/8/2011, completed 1/25/2012 • #149 – Date of hire 9/7/2011, completed 12/27/2011 • #161 – Date of hire 8/8/2011, completed 8/11/2011 • #165 – Date of hire 9/21/2011, completed 9/29/2011 • #180 – Date of hire 12/1/2007, completed 3/7/2012 • #182 – Date of hire 12/1/2007, completed 3/7/2012	

Standard of Care	*March 5 – 9, 2012 Deficiencies*	November 13 - 15, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 CQI System	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS** **I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;	Based on record review and interview, the Agency failed to implement a complete Continuous Quality Management System. Review of the Agency's Continuous Quality Improvement Plan provided during the on-site survey indicated the agency had a CQI committee which was functional and met regularly. Interview with the Executive Director (#91) and the General Manager (#218) indicated routine peer reviews of Agency files and personnel files. During interviews it was reported that the Agency's Family Support Managers were responsible for CQI of their assigned Family Living Providers and Community Access Personnel. The Adult Hab Manager was responsible for the CQI process as it relates to Adult Habilitation. Yet review of these areas found significant and substantial deficiencies which either were not corrected nor identified.	**New/Repeat Finding:** Based on record review, the Agency failed to implement a Continuous Quality Management System. Review of the findings from the March 5 - 9, 2012 survey indicated the Agency had significant deficiencies noted. Nevertheless, during the verification survey the agency continues to have repeat deficiencies which were not sufficiently addressed since the last survey.

(6) Quality and completeness documentation; and (7) Trends in individual and guardian satisfaction. **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:** **E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system: **(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements; **(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place; **(4)** community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.		

Tag # 1A15.2 & 5I09 - Healthcare Documentation	*Condition of Participation Level Deficiency*	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments 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,	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 18 of 22 individual The following were not found, incomplete and/or not current: • Electronic Comprehensive Health Assessment Tool (e-Chat) (#2 & 13) • Medication Administration Assessment Tool (#16) • Comprehensive Aspiration Risk Assessment Tool (#3, 12, 13 & 19) • Aspiration Risk Management Screening Tool (#21) • Health Passport (#2, 6, 7, 13, 15 & 19) • **Quarterly Nursing Review of HCP/Crisis Plans:** ° None found for 10/2011 – 12/2011 (#11) ° None found for 4/2011 – 12/2011 (#12) ° None found for 11/2011 – 1/2012 (#18) ° None found for 4/2011 – 9/2011 (#19) • **Special Health Care Needs:** • *Meal Time Plan* ° Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No current plan found.	**Repeat Finding:** Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 21 individual The following were not found, incomplete and/or not current: • Comprehensive Aspiration Risk Assessment Tool (#12) • **Health Care Plans** • *Alcoholism* ° Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Bi-Polar Diagnosis* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Hypertension Diagnosis* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Increased Lipids* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found.

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, 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	◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No current plan found. • *Nutritional Plan* ◦ Individual #9 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #15 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. • *Tube Feeding* ◦ Individual #12 - As indicated by the IST section of ISP the individual is required to have a plan. No current plan found. • **Health Care Plans** • *Alcoholism* ◦ Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Aspiration* ◦ Individual #4 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #10 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic	

professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. (3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other	Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Bi-Polar* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Body Mass Index* ◦ Individual #6 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Bowel & Bladder* ◦ Individual #10 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Colostomy* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.	

interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person. (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.	◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Hypertension* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Oral Care* ◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Increased Lipids* Individual #2 - As indicated by the ISP the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Skin & Wound* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the	

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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.	individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *“Trispmy 8” [sic]* Individual #9 - As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. • **Crisis Plans/Medical Emergency Response Plans** • *Aspiration* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #4 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #16 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.	

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.	◦ Individual #20 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *GERD* ◦ Individual #17 – As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. • *Pressure Ulcer Risk* ◦ Individual #3 – As indicated by the IST section of the ISP the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #2 - As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizures* ◦ Individual #3 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #12 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #19 – As indicated by the Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.	

Tag # 6L13 Community Living Healthcare Reqts.	*Condition of Participation Level Deficiency*	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 18 of 22 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Annual Physical** (#3, 5, 7, 9, 10, 12, 13, 14, 16, 17, 18, 19 & 20) • **Dental Exam** ° Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 1/4/2010 and follow-up on 3/29/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. ° Individual #3 - As indicated by collateral documentation reviewed, the exam was completed on 12/8/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. ° Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ° Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ° Individual #6 - As indicated by the DDSD file	**New/Repeat Finding:** Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 21 individuals receiving Community Living Services. The following was not found, incomplete and/or not current: • **Dental Exam** ° Individual #18 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ° Individual #10 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #18 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings** ° None found 2/2012 – 10/2012 for Geodon (#18)

on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes	matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #9 - As indicated by collateral documentation reviewed, exam was completed on 10/20/2011. Follow-up was to be completed in 3 months. No evidence of follow-up found. ◦ Individual #13 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #17 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #18 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of 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. ◦ Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #9 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #10 - As indicated by the DDSD file	

results of laboratory and radiology procedures or progress following therapy or treatment.	matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #12 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #13 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #14 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #16 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #17 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #18 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #19 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #20 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #21 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #22 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.	

	• **Blood Levels**
	  ◦ Individual #6 - As indicated by collateral documentation reviewed, lab work was completed on 8/31/2011. No evidence of lab results were found.
	
	• **Review of Psychotropic Medication**
	  ◦ Individual #6 - As indicated by collateral documentation reviewed last appointment was completed 6/27/2011. The individual was to follow-up in 4 – 6 weeks. No evidence was found indicating follow-up was completed.
	
	• **EKG**
	  ◦ Individual #6 - As indicated by collateral documentation reviewed the Individual's Physician had ordered an EKG on 6/27/2011. No evidence was found indicating exam was completed.
	
	• **Abnormal Involuntary Movement Screening and/or Tardive Dyskinesia Screenings**
	  ◦ None found 3/2011 - 2/2012 for Geodon (#10)
	  ◦ None found 3/2011 - 2/2012 for Geodon (#18)
	  ◦ None found 4/2011 - 2/2012 for Geodon (#21)	

Standard of Care	*March 5 – 9, 2012 Deficiencies*	November 13 - 15, 2012 Deficiencies Verification Survey – New and Repeat Deficiencies
CMS Assurance – Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A08 Agency Case File	Standard Level Deficiency	Completed
Tag # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency	Completed
Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Standard Level Deficiency	Completed
Tag # 5I11.1 Reporting Requirements (CI Quarterly Report Components)	Standard Level Deficiency	Completed
Tag # 6L14 Residential Case File	Standard Level Deficiency	Completed
Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)	Standard Level Deficiency	Completed
CMS Assurance – Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A11.1 Transportation Training	Standard Level Deficiency	Completed
Tag # 1A22 Agency Personnel Competency	*Condition of Participation Level Deficiency*	Completed
Tag # 1A25 Criminal Caregiver History Screening	*Condition of Participation Level Deficiency*	Completed
Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Completed
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	Completed
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		

Tag # 1A06 Provider Agency Policy & Procedure Requirements	Standard Level Deficiency	Completed
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Standard Level Deficiency	Completed
Tag # 1A09.1 Medication Delivery - PRN Medication	Standard Level Deficiency	Completed
Tag # 1A29 Complaints / Grievances - Acknowledgement	Standard Level Deficiency	Completed
Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency	Completed
Tag # 1A33 Board of Pharmacy - Med Storage	Standard Level Deficiency	Completed
Tag #1A39 Assistive Technology & Adaptive Equipment	Standard Level Deficiency	Completed
Tag # 6L06 Family Living Requirements	*Condition of Participation Level Deficiency*	Completed
Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)	Standard Level Deficiency	Completed
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.		
Tag # 5I36 Community Access Reimbursement	Standard Level Deficiency	Completed
Tag # 5I44 Adult Habilitation Reimbursement	Standard Level Deficiency	Completed
Tag # 6L27 Family Living Reimbursement	Standard Level Deficiency	Completed

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO
DEPARTMENT OF
HEALTH

RETTA WARD, CABINET SECRETARY

Date: March 6, 2013

To: Cruz Rojas, Executive Director
Provider: Grace Requires Understanding, Inc.
Address: 1100 S. Main Suite A
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: cmrojas@mygru.org

CC: Victor Duran, Board Chair
Address: P. O. Box 2334
State/Zip: Mesilla Park, NM 88047
E-Mail Address: victord3@msn.com

Region: Southwest
Routine Survey: March 5 - 9, 2012
Verification Survey: November 13 – 15, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Living Supports (Family Living & Independent Living) & Inclusion Supports (Community Access)
Survey Type: Verification

Dear Ms. Rojas:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

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

Q.13.4.DDW.D3861.3.001.VER.09.065