Date: February 9, 2009

To: W. Azul La Luz, Executive Director
Provider: Las Cumbres Learning Services
Address: 404 Hunter Street
State/Zip: Espanola, New Mexico 87532

E-mail Address: azul.laluz@lascumbres-nm.org

Cc. Al Hernandez, President, Board of Directors
Address: P. O. Box 99
City, zip Espanola, New Mexico 87532

Region: Northeast
Survey Date: January 5 - 8, 2009
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living & Independent Living) & Community Inclusion (Supported Employment & Community Access)
Survey Type: Routine
Team Leader: Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Cindy Nielsen MSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Florie Alire, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Survey #: Q09.03.D0606.NE.001.RTN.01

Dear Mr. La Luz:

The Division of Health Improvement Quality Management Bureau has completed a quality review 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.

Quality Management Approval Rating:
The Division of Health Improvement is granting your agency a "STANDARD" certification for basic compliance with DDSD Standards and regulations.

Plan of Correction:
The attached Report of Findings identifies deficiencies found during your agency's survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency's Plan of Correction (POC) in the space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. The response is due to the parties below within 10 working days of the receipt of this letter:

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   5301 Central Ave. NE Suite 900 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 within 45 working days. If your plan of correction is denied, you must resubmit a revised plan ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

Failure to submit, complete or implement your POC within the required time frames will 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 determination of noncompliance (finding) you have 10 working 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 #900
Albuquerque, NM 87108
Attention: IRF request

A request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition, sampling methodology or the Scope and Severity of the finding.

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-841-5831, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Marti Madrid, LBSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	January 5, 2009
Present:	**Las Cumbres Learning Services** Megan Delano, Director of Administration & Operations **DOH/DHI/QMB** Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Cindy Nielsen, RN, MSN, ONC, CCM, Healthcare Surveyor Florie Alire, RN, Healthcare Surveyor Nadine Romero, LBSW, Healthcare Surveyor
Exit Conference Date:	January 8, 2009
Present:	**Las Cumbres Learning Services** W. Azul La Luz, Executive Director Megan Delano, Director of Administration & Operations Sergio Garcia, Adult Services Director **DOH/DHI/QMB** Marti Madrid, LBSW, Team Lead/Healthcare Surveyor Cindy Nielsen, RN, MSN, ONC, CCM, Healthcare Surveyor Florie Alire, RN, Healthcare Surveyor Barbara Czinger, MSW, LISW, Healthcare Surveyor **DDSD - Northeast Regional Office** Tom Trujillo, Special Projects Coordinator
Homes Visited	Number: 2 (2 individuals lived in each home)
Administrative Locations Visited	Number: 2 (103 Coronado & 404 Hunter, Espanola, NM)
Total Sample Size	Number: 8 4 - Supported Living 4 - Independent Living 7 - Supported Employment 6 - Community Access
Persons Served Interviewed	Number: 3
Persons Served Observed	Number: 5 (Observations were completed as the Individuals were working at the time of the visits)
Records Reviewed (Persons Served)	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 • Human Rights Notes and/or Meeting Minutes

- Nursing personnel files
- Evacuation Drills
- Quality Improvement/Quality Assurance Plan

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

Attachment A

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency ("Responsible Party"), and by WHEN ("Date Due").
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency's Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to George.Perrault@state.nm.us, by fax (505-841-5815), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been "Approved" or "Denied".
- Whether your POC is "Approved" or "Denied", you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is "Denied" it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):

    - CCHS and EAR: 10 working days
    - Medication errors: 10 working days
    - IMS system/training: 20 working days
    - ISP related documentation: 30 working days
    - DDSD Training 45 working days

- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8624 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.

- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Attachment B

QMB Scope and Severity Matrix of survey results

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Certification.

			SCOPE		
SEVERITY			**Isolated 01% - 15%**	**Pattern 16% - 79%**	**Widespread 80% - 100%**
	High Impact	Immediate Jeopardy to individual health and or safety	**J.**	**K.**	**L.**
		Actual harm	**G.**	**H.**	**I.**
	Medium Impact	No Actual Harm Potential for more than minimal harm	**D.**	**E.**	**F.** (3 or more)
			D. (2 or less)		**F.** (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	**A.**	**B.**	**C.**

Scope and Severity Definitions:

Key to Scope scale:

Isolated:
A deficiency that is limited to 1% to 15% of the sample, usually impacting no more than one or two individuals in the sample.

Pattern:
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.

Widespread:
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings must be referred to the Internal Review Committee for review and possible actions or sanctions.

Key to Severity scale:

Low Impact Severity: (Blue)
Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a "C" level may receive a "Quality" Certification approval rating from QMB.

Medium Impact Severity: (Tan)
Medium level findings have a potential for harm to an individual. Providers that have no findings above a "F" level and/or no more than two F level findings and no F level Conditions of Participation may receive a "Merit" Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)
High level findings are when harm to an individual has occurred. Providers that have no findings above "I" level may only receive a "Standard" Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)
"J, K, and L" Level findings:
This is a finding of Immediate Jeopardy. If a provider is found to have "I" level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

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

Introduction:
Throughout the process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding.

To informally dispute a finding the provider must request in writing an Informal Reconsideration of the Finding (IRF) to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

The written request for an IRF must be completed on the **QMB Request for Informal Reconsideration of Finding Form** (available on the QMB website) and must specify in detail the request for reconsideration and why the finding is inaccurate. The **IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received in 10 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 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 Scope and Severity of a finding.
- 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 QMB Quality Approval Rating and the length of their DDSD provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. 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 successfully reconsidered, it will be noted and will be removed or modified from the report. 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.

Administrative Review Process:
If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDSD Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

Regarding IRC Sanctions:
The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

Agency: **Las Cumbres Learning Services - Northeast Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living & Independent Living) & Community Inclusion (Community Access & Supported Employment)
Monitoring Type: Routine
Date of Survey: **January 5 - 8, 2009**

Statute	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
Tag # 1A08 Agency Case File	**Scope and Severity Rating: B**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 4 of 8 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Current Emergency & Personal Identification Information (#1 & 4) • Annual ISP (#7) • ISP Signature Page (#7) • Addendum A (#7) • Individual Specific Training (Addendum B) (#7) • Occupational Therapy Plan (#5)		

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.			

Tag # 1A09 Medication Delivery (MAR)	Scope and Severity Rating: D		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for	Based on record review of September, October and November, 2008 Medication Administration Records (MAR) 4 of 8 individuals had MARs which contained missing medications entries and/or other errors: Individual #1 September 2008 Medication Administration Records for the following medications do not contain the purpose of the medication: • Tears Natural II Eye Drops Medication Administration Records for the following medications do not contain the dosage, frequency & purpose of the medication: • Clariton October 2008 MAR contained missing entries. No documentation found indicating reason for missing entries: • Fluoxetine 20mg (one time daily) - Blank - October 29, 2008 (am dosage). • Ranitidine 150 mg (one time daily) - Blank - October 28, 2008 (pm dosage). • Sulindac 200mg (two times daily) - Blank - October 29, 2008 (am dosage). • Seroquel 25mg (2 tablets by mouth at bedtime) - Blank - 2 tablets October 28, 2008 (pm dosage). • Vitamin C 500 mg (two times daily) - Blank - October 28 (pm dosage) & October 29, 2008 (am dosage). • Oyster Shell Calcium 500 mg (two times daily) - Blank - October 28 (pm dosage) & October 29, 2008 (am dosage). • Clindamycin PH 1% gel (two times daily) - Blank - October 28 (pm dosage) & October		

the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials;	29, 2008 (am dosage). • Gemfibrozil 600 mg (one time daily) - Blank - October 29, 2008 (am dosage). • Levothyroxine 25mcg (one time daily) - Blank - October 29, 2008 (am dosage). • Glucosamine 1000mg (two times daily) - Blank - October 28 (pm dosage) & October 29, 2008 (am dosage). • Fish Oil Capsules 1 capsule (two times daily) - Blank - October 28 (pm dosage) & October 29, 2008 (am dosage). Individual #3 September 2008 Medication Administration Records for the following medications do not contain the purpose of the medication: • Chlotrimazole 1% cream • Oxybutinin 5mg • Verapamil SA 120 mg • Sertraline 100mg • Vitamin C 500 mg • Colestipol 1 gm tab October 2008 Medication Administration Records for the following medications do not contain the purpose of the medication: • Chlotrimazole 1% cream • Oxybutinin 5mg • Verapamil SA 120 mg • Sertraline 100mg • Vitamin C 500 mg • Colestipol 1 gm tab November 2008 Medication Administration Records for the following medications do not contain the purpose of the medication: • Chlotrimazole 1% cream • Oxybutinin 5mg		

(ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications.	• Verapamil SA 120 mg • Sertraline 100mg • Vitamin C 500 mg • Colestipol 1 gm tab Individual #4 September 2008 Medication Administration Records for the following medications did not contain the purpose of the medication: • Depakote 250 mg ec tab • Vitamin C 500 mg tab • Cerovite advance vitamin • Fiber Laxative Tablet • Tears Natural ll Eye Drops October 2008 Medication Administration Records for the following medications do not contain the purpose of the medication: • Depakote 250 mg ec tab • Vitamin C 500 mg tab • Cerovite advance vitamin • Fiber Laxative Tablet • Tears Natural ll Eye Drops November 2008 Medication Administration Records for the following medications do not contain the purpose for the medication: • Depakote 250 mg ec tab • Vitamin C 500 mg tab • Cerovite advance vitamin • Fiber Laxative Tablet • Tears Natural ll Eye Drops MAR contained missing entries. No documentation found indicating reason for missing entries: • Cerovite Advance Vitamin (one time daily) - Blank - October 8, 2008.		

	• Tears Natural ll Eye Drops (three times daily) - Blank - October 23, 2008 (pm dosage) & October 20, 2008 (pm dosage) • Fiber Laxative Tablet (one time daily) - Blank - October 17, 2008. Individual # 5 September 2008 Medication Administration Records for the following medications do not contain the purpose for the medication: • Fiber Laxative tablet • Omeprazole 20 mg • Glucosamine/Chondriton • Eucerin Lotion • Levothyroxine 75 mg October 2008 Medication Administration Records for the following medications do not contain the purpose for the medication: • Fiber Laxative tablet • Omeprazole 20 mg • Glucosamine/Chondriton • Eucerin Lotion • Levothyroxine 75 mg November 2008 Medication Administration Records for the following medications do not contain the purposed for the following medications: • Fiber Laxative tablet • Omeprazole 20 mg • Glucosamine/Chondriton • Eucerin Lotion • Levothyroxine 75 mg		

Tag # 1A15 Healthcare Documentation	Scope and Severity Rating: E		
Developmental Disabilities (DD) Waiver Service Standards 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. **(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	Based on record review the Agency failed to maintain the required documentation in the Individuals Agency Records as required per standard for 2 of 8 individual The following was missing or not current: • Health Assessment Tool (#7) • Medication Administration Assessment Tool (#7) • Seizure Crisis Plan (#4)		

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, method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **(2) Health related plans**			

(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. (b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. (c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. (d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings. **(3)** For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended): (a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition. (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the			

goal. (c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan. (d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions. (e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings. (f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization. (g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author. (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed. **(4) General Nursing Documentation** (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be			

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

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E		
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 15 of 25 Direct Service Personnel. Review of Direct Service Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #24) • Basic Health/Orientation (DSP #24) • Person-Centered Planning (1-Day) (DSP #18) • First Aid (DSP #10, 20, 22, 24, 25, 26, 27 & 29) • CPR (DSP #10, 20, 22, 24, 25 & 29) • Assisting With Medications (DSP #15 & 17) • Rights & Advocacy (DSP #14, 16, 18, 21 & 25) • Level 1 Health (DSP #14, 16, 18, 20, 21, 22, 24 & 25) • Teaching & Support Strategies (DSP #12, 14, 21 & 25) • Positive Behavior Supports Strategies (DSP #22 & 25) • Participatory Communication & Choice Making (DSP #17, 22, 24, 25 & 27)		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: E		
NMAC 7.1.13.10 **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **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. **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.	Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 5 of 25 Agency Personnel. • Incident Management (Abuse, Neglect & Exploitation) (#21, 24, 25, 26 & 27)		

Tag # 1A28 (CoP) Incident Mgt. System	Scope & Severity Rating: D		
NMAC 7.1.13.10 **INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **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. E. **Consumer and Guardian Orientation Packet:** 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.	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 or exploitation for 1 of 8 individuals. • Parent/Guardian Incident Management (Abuse, Neglect & Exploitation) Training (#7)		

Tag # 1A29 Complaints / Grievances	Scope and Severity Rating: B		
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	Based on record review, the Agency failed to provide documentation that the complaint procedure had been made available to individuals or their legal guardians for 3 of 8 individuals. • Grievance/Complaint Procedure (#1, 5 & 7)		

Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: E		
NMAC **7.26.5.16.C and D** **Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	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 8 individuals. Per Individuals ISP's the following was found with regards to the implementation of ISP Outcomes: Community Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: • None found for 9/2008; 10/2008 & 11/2008 (Individual #4) • None found for May 2008 - September 2008 (Individual # 6)		

Tag # 5I25 SE Reimbursement	Scope and Severity Rating: A		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **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 then 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 acquisition progress; (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.	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 8 individuals Individual 5 • October 11, 17, 18 & 31, 2008 - Agency billed a total of 47.5 hours of Supported Employment. Documentation received accounted for 12 hours. • November 5, 6, 12, 13, & 26 2008 - Agency billed a total of 31.0 hours of Supported Employment. Documentation received accounted for 2.5 hours.		

(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.			

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E		
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, which ever 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	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 8 individuals. • Annual Physical (# 7) • Depakote and Tegretol Levels were drawn 1/2008 per documentation found. No results were found in Agency Record. (#6)		

Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition. (4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT. (5) That the physical property and grounds are free of hazards to the individual's health and safety. (6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following: (a) The individual has a primary licensed physician; (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician; (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).			