Dear Ms. Hooten;

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

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

**Compliance with all Conditions of Participation.**

This determination is based on your agency’s compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

*Deb Russell, BS*

Deb Russell, BS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: June 10, 2013

Present:

**LEADERS Industries**
- Reba Armendariz, Independent Living Administrator
- Norma Ornelas, Service Coordinator
- Kim Crowder, Service Coordination Administrator
- Tina Thompson, Day Habilitation Administrator
- Paulie Gladden, Supported Living Administrator

**DOH/DHI/QMB**
- Deb Russell, BS, Team Lead/Healthcare Surveyor
- Cyndie Neilsen, RN, Healthcare Surveyor

Exit Conference Date: June 14, 2013

Present:

**LEADERS Industries**
- Reba Armendariz, Independent Living Administrator
- Felicia Hicks, Supported Living Administrative Assistant
- Donna Hooten, Executive Director
- Norma Ornelas, Service Coordinator
- Kim Crowder, Service Coordination Administrator
- Barbara Rush, Administrative Assistant
- Tina Thompson, Day Habilitation Administrator
- Paulie Gladden, Supported Living Administrator
- Donna Waits, RN, Health Services Administrator

**DOH/DHI/QMB**
- Deb Russell, BS, Team Lead/Healthcare Surveyor
- Cyndie Neilsen, RN, Healthcare Surveyor
- Mari Chavez, BSW, Healthcare Surveyor

**DDSD - Southeast Regional Office**
- Michelle Lyon, Regional Office Manager (via telephone conference)
- Paul Scwhalje, Regional Office Bureau Chief (via telephone conference)

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 11
0 - Jackson Class Members
1 - Non-Jackson Class Members
7 - Supported Living
4 - Independent Living
9 - Adult Habilitation
7 - Community Access
5 - Supported Employment

Total Homes Visited
Number: 5
- Supported Living Homes Visited Number: 5

Persons Served Records Reviewed
Number: 11

Persons Served Interviewed
Number: 6
Persons Served Observed Number: 5 (One Individual did not respond to surveyor questions and 4 Individuals chose not to participate in the interview process as they were involved in other activities)

Direct Support Personnel Interviewed Number: 11

Direct Support Personnel Records Reviewed Number: 50

Service Coordinator Records Reviewed Number: 2

Administrative Processes and Records Reviewed:

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

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

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

The following details should be considered when developing your POC:

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.

2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-699-9356 for assistance.

3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.

4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
   a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108

5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.

6. QMB will notify you when your POC has been “approve” or “denied.”
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

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

**POC Document Submission Requirements**

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

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

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.
The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency’s operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

**Service Domain: Level of Care**

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

**Service Domain: Plan of Care**

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

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

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

**Service Domain: Qualified Providers**

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

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

**Service Domain: Plan of Care**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status. If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
**Agency:** LEADERS Industries - Southeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living Supports (Supported Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)  
**Monitoring Type:** Routine Survey  
**Survey Date:** June 10 – 14, 2013

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| **Service Domain: Service Plans: ISP Implementation** – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan. | **Tag # 1A08 Agency Case File**  
Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 11 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
- Physical Therapy Plan (#3) | **Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: → |          |

**CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.

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

1. Emergency contact information, including the individual’s address, telephone number, names and telephone numbers of relatives,
or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;

(2) The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);

(3) Progress notes and other service delivery documentation;

(4) Crisis Prevention/Intervention Plans, if there are any for the individual;

(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;

(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and

(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.

(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:

(a) Complete file for the past 12 months;

(b) ISP and quarterly reports from the current and prior ISP year;

(c) Intake information from original admission to services; and

(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

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

B. **Documentation of test results**: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1</th>
<th>Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 11 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here:</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Review of the Agency individual case files revealed the following items were not found:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td>Community Access Progress Notes/Daily Contact Logs • Individual #5 - None found for 2/2013 – 4/2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Progress notes and other service delivery documentation;</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.4.DDW.D0612.4.001.RTN.01.204

Page 15 of 62
### Tag #1 A32 and 6L14
**Individual Service Plan Implementation**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not 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 11 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

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 #5
  - None found for 6/2012 – 5/2013.

#### Residential Files Reviewed:
**Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**
- Individual #1

When asked where to find the Supported Living data collection DSP #49 stated, "The weekend person hasn’t been documenting. It’s being done."

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**NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.** The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.

C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]
<table>
<thead>
<tr>
<th>Tag # 5I11.1 Reporting Requirements (CI Report Components)</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not complete written quarterly status reports in compliance with standards for 3 of 11 individuals receiving Community Inclusion Services.</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</td>
<td>Review of quarterly reports found the following components were not addressed, as required:</td>
<td></td>
</tr>
<tr>
<td>E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual’s Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</td>
<td>Individual #5 - The following components were not found in the Community Access Quarterly Report for 6/2012 – 3/2013:</td>
<td></td>
</tr>
<tr>
<td>(1) Identification and implementation of a meaningful day definition for each person served;</td>
<td>(1) Identification and implementation of a meaningful day definition for each person served;</td>
<td></td>
</tr>
<tr>
<td>(2) Documentation summarizing the following:</td>
<td>(2) Documentation summarizing the following:</td>
<td></td>
</tr>
<tr>
<td>(a) Daily choice-based options; and</td>
<td>(b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.</td>
<td></td>
</tr>
<tr>
<td>(b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.</td>
<td>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP.</td>
<td></td>
</tr>
<tr>
<td>(3) Significant changes in the individual’s routine or staffing;</td>
<td>Individual #6 - The following components were not found in the Community Access Quarterly Report for 6/2012 – 3/2013:</td>
<td></td>
</tr>
<tr>
<td>(4) Unusual or significant life events;</td>
<td>(2) Documentation summarizing the following:</td>
<td></td>
</tr>
<tr>
<td>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</td>
<td>(b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.</td>
<td></td>
</tr>
<tr>
<td>(6) Record of personally meaningful community inclusion;</td>
<td>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP.</td>
<td></td>
</tr>
<tr>
<td>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP.</td>
<td>Individual #8 - The following components were not found in the Community Access Quarterly Report for 10/2012 – 4/2013:</td>
<td></td>
</tr>
<tr>
<td>(8) Any additional reporting required by DDSD.</td>
<td></td>
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</tr>
</tbody>
</table>

(2) Documentation summarizing the following:
(b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.

(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP.
<table>
<thead>
<tr>
<th>Tag # 6L14</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Case File</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 7 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td></td>
</tr>
<tr>
<td>A. Residence Case File: For individuals receivingSupported Living or Family Living, the Agency shall maintain in the individual’s home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual’s home, the complete and current confidential case file for each individual shall be maintained at the agency’s administrative site. Each file shall include the following:</td>
<td></td>
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<tr>
<td>(1) Complete and current ISP and all supplemental plans specific to the individual;</td>
<td></td>
</tr>
<tr>
<td>(2) Complete and current Health Assessment Tool;</td>
<td></td>
</tr>
<tr>
<td>(3) Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician’s name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;</td>
<td></td>
</tr>
<tr>
<td>(4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);</td>
<td></td>
</tr>
<tr>
<td>(5) Data collected to document ISP Action Plan implementation</td>
<td></td>
</tr>
<tr>
<td>(6) Progress notes written by direct care staff</td>
<td></td>
</tr>
</tbody>
</table>

Provider:

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

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

Provider:

Provider:

Provider:

Provider:

Provider:
and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
(7) Physician’s or qualified health care providers written orders;
(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);
(9) Medication Administration Record (MAR) for the past three (3) months which includes:
(a) The name of the individual;
(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
(c) Diagnosis for which the medication is prescribed;
(d) Dosage, frequency and method/route of delivery;
(e) Times and dates of delivery;
(f) Initials of person administering or assisting with medication; and
(g) An explanation of any medication irregularity, allergic reaction or adverse effect.
(h) For PRN medication an explanation for the use of the PRN must include:
   (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
   (ii) Documentation of the effectiveness/result of the PRN delivered.
(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual’s home and an updated copy must be placed in the agency file on a weekly basis.

| Individual #9 | None found for 6/5 – 10, 2013. |
| Individual #10 | None found for 6/7 – 9, 2013. |
| Individual #11 | None found for 6/5 – 10, 2013. |
| Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and |
| Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam. |
### Standard of Care

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

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Standard Level Deficiency</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A11.1</td>
<td><strong>Transportation Training</strong></td>
<td></td>
</tr>
</tbody>
</table>


**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...

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

**II. POLICY STATEMENTS:**

I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be

Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 17 of 50 Direct Support Personnel.

**No documented evidence was found of the following required training:**

- Transportation (DSP #40, 42, 43, 46, 47, 49, 57, 64, 75, 77, 79, 80, 85, 86, 87, 89, 91)

When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:

- DSP #47 stated, “No but I’ve only been in this home for 1 week.”
- DSP #64 stated, “No wheelchair or van lift yet.”

**Provider:**

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

Provider:

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff’s role)
6. Wheelchair tie-down procedures (if applicable to the staff’s role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 20 of 50 Direct Support Personnel and Supervisors.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER I IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
<td></td>
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<tr>
<td>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
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<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
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<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
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<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td>• Pre- Service (DSP #42, 43, 47, 48, 51, 57, 67, 72, 79, 85)</td>
<td></td>
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<td></td>
<td>• Foundation for Health and Wellness (DSP #40, 42, 43, 47, 48, 51, 57, 67, 72, 79, 84, 85, 86)</td>
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</tr>
<tr>
<td></td>
<td>• Person-Centered Planning (1-Day) (DSP #42, 43, 47, 51, 57, 67, 72, 79, 85, 86)</td>
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</tr>
<tr>
<td></td>
<td>• First Aid (DSP #59, 78)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• CPR (DSP #59, 78)</td>
<td></td>
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<tr>
<td></td>
<td>• Assisting With Medication Delivery (DSP #46, 87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participatory Communication and Choice Making (DSP #40, 49, 51, 55, 57, 78, 82, 84, 87)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Advocacy 101 (DSP #57)</td>
<td></td>
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<tr>
<td></td>
<td>• Positive Behavior Supports Strategies (DSP #57)</td>
<td></td>
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<tr>
<td></td>
<td>• Teaching and Support Strategies (DSP #40, 49, 51, 57)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.
F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.
G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques.
Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.
H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
### Tag # 1A22
**Agency Personnel Competency**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on interview, the Agency did not ensure training competencies were met for 5 of 11</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Direct Support Personnel.</td>
<td></td>
</tr>
<tr>
<td><strong>When DSP were asked if they received training on the Individual's Individual Service</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Plan and what the plan covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>- DSP #71 stated, “No.” (Individual #7)</td>
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<tr>
<td><strong>When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so,</strong></td>
<td></td>
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<tr>
<td><strong>what the plan covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>- DSP #71 stated, “Not too sure.” According to the Individual Specific Training Section of</td>
<td></td>
</tr>
<tr>
<td>the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #7)</td>
<td></td>
</tr>
<tr>
<td><strong>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>- DSP #53 stated, “Seizure, Back Pain and High Risk Meds.” As indicated by the Agency file,</td>
<td></td>
</tr>
<tr>
<td>the Individual also has Health Care Plans for Oral Care and fall. (Individual #11)</td>
<td></td>
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<tr>
<td>- DSP #65 stated, “Diabetes and Skin Integrity.” As indicated by the Agency file, the</td>
<td></td>
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<tr>
<td>Individual also has Health Care Plans for Urinary Calculus and Low Sodium/Fluid Restriction. (Individual #8)</td>
<td></td>
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<tr>
<td>- DSP #73 stated, “When she is out of breath she takes inhaler. I forgot where they are</td>
<td></td>
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<tr>
<td>said in Spanish.” As indicated by the Agency file, the Individual also has Health Care Plans</td>
<td></td>
</tr>
</tbody>
</table>

**Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007**

**CHAPTER I IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.

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

1. Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;
2. Direct service personnel shall have the ability to read and carry out the requirements in an ISP;
3. Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;
4. Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for
Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

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

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:

(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;

(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and

(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

Department of Health (DOH) Developmental 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.

file, the Individual also has a Health Care Plan for Body Mass Index. (Individual #9)

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

- DSP #53 stated, “Seizure, High Risk Meds and Pain.” As indicated by the Agency file, the Individual also has a Medical Emergency Response Plan for fall. (Individual #11)

- DSP #65 stated, “Urinary, Kidney Stones, High Risk Medications and Diabetes.” As indicated by the Agency file, the Individual also has a Medical Emergency Response Plan for Water Intoxication. (Individual #8)

- DSP #70 stated, “No.” As indicated by the Agency file, the Individual also has a Medical Emergency Response Plan for COPD. (Individual #3)

- DSP #73 stated, “Antipsychotics, Neuroleptic Malignant Syndrome and Allergy to Penicillin.” As indicated by the Agency file, the Individual also has a Medical Emergency Response Plan for COPD. (Individual #9)

When DSP were asked who provided training on the Individual’s Seizure Disorder, the following was reported:

- DSP #53 stated, “I have never been trained on that.” According to the Individual’s Health Care Plan and Medical Emergency Response Plan, the individual has a diagnosis of Seizures. (Individual #11)
<table>
<thead>
<tr>
<th>Tag # 1A25</th>
<th>Criminal Caregiver History Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: F. Timely Submission: Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS: A. Prohibition on Employment: A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</td>
<td></td>
</tr>
<tr>
<td>NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider: A. homicide; B. trafficking, or trafficking in controlled substances; C. kidnapping, false imprisonment, aggravated assault or aggravated battery; D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</td>
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</tr>
<tr>
<td>Based on record review, the Agency did not maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 1 of 52 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings: Direct Support Personnel (DSP): • #83 – Date of hire 5/9/2013.</td>
<td></td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
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<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</tbody>
</table>
E. crimes involving adult abuse, neglect or financial exploitation;

F. crimes involving child abuse or neglect;

G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
<table>
<thead>
<tr>
<th>Tag # 1A26</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated On-line Registry</td>
<td>Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 52 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Employee Abuse Registry</td>
<td>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

**D. Documentation of inquiry to registry.** The provider shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 52 Agency Personnel.

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

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

Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 52 Agency Personnel.

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

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

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

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


**Chapter 1.IV. General Provider Requirements.**  
**D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Incident Mgt. System - Personnel Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1A28.1</td>
<td>Standard Level Deficiency</td>
</tr>
</tbody>
</table>

**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.

**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.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

Based on record review and interview, the Agency did not ensure Incident Management Training for 11 of 52 Agency Personnel.

**Direct Support Personnel (DSP):**
- Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP# 43, 52, 54, 62, 64, 70, 75, 90, 92)

**Service Coordination Personnel (SC):**
- Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (SC #94)

When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:

- DSP #71 stated, "Adult Protective Services." Staff was not able to identify the 2nd State Agency as Division of Health Improvement/Incident Management Bureau.

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

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
## Tag #1 A36

### Service Coordination Requirements


**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.

### Standard Level Deficiency

Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 2 of 2 Service Coordinators.

Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:

- Pre-Service Manual (SC #93, 94)
- Person Centered Planning (2-Day) (SC #93)

**Provider:**

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

Provider:

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

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
<table>
<thead>
<tr>
<th>Tag # 1A37</th>
<th>Individual Specific Training</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 6 of 52 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of personnel records found no evidence of the following:</td>
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<tr>
<td>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
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<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td>• Individual Specific Training (DSP #43, 46, 48, 57, 85)</td>
<td></td>
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<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
<td><strong>Service Coordination Personnel (SC):</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Individual Specific Training (SC #93)</td>
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**Service Domain: Health and Welfare** – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>CQI System</td>
<td>Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard. Review of the Agency’s CQI Plan revealed the following:</td>
</tr>
</tbody>
</table>

- The Agency’s Continuous Quality Improvement Plan provided during the on-site survey June 13, 20123 was not dated. No evidence was found indicating when the document had been created or updated. Also, based on evidence found during the on-site survey and reflected in this report of findings the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.

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

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
supervisory and direct support levels;
(6) Quality and completeness documentation; and
(7) Trends in individual and guardian satisfaction.

7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR
COMMUNITY BASED SERVICE PROVIDERS:
E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

<p>| | |</p>
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<tbody>
<tr>
<td>(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;</td>
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<tr>
<td>(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;</td>
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<tr>
<td>(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.</td>
<td></td>
</tr>
<tr>
<td>Tag # 1A09</td>
<td>Medication Delivery Routine Medication Administration</td>
</tr>
</tbody>
</table>
|------------|--------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------------
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Medication Administration Records (MAR) were reviewed for the months of April, May and June 2013. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. | Based on record review, 2 of 7 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: | |
| 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. | Individual #1 June 2013 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: | |
| (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: | • Risperdal 3mg (2 times daily) – Blank 6/2 (8:00 PM) | |
| (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; | • Lithium Carbonate 300mg (3 times daily) – Blank 6/11 (1:00 PM) | |
| (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; | Individual #8 April 2013 During on-site survey Medication Administration Records were requested for months of April, May and June 2013. As of 6/14/2013, Medication Administration Records for April had not been provided. | |
| (c) Initials of the individual administering or | | |
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;

NMAC 16.19.11.8 MINIMUM STANDARDS:
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;
   (ii) Date given;
   (iii) Drug product name;
   (iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

**Model Custodial Procedure Manual**

**D. Administration of Drugs**

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.
### Tag # 1A09.1
**Medication Delivery**
**PRN Medication Administration**

**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

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Records (MAR) were reviewed for the months of April, May and June 2013.</td>
<td></td>
</tr>
</tbody>
</table>
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;

(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

**NMAC 16.19.11.8 MINIMUM STANDARDS:**

**A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:**

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;
   (ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual

D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Department of Health
Developmental Disabilities Supports
Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006

F. PRN Medication

3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress
(including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

**H. Agency Nurse Monitoring**

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual’s response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse’s assessment of the individual and consideration of the individual’s diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual’s condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual’s response to medication.

*Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:*
Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and 5I09</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Documentation</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 11 individual</td>
</tr>
<tr>
<td>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.</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 11 individual</td>
</tr>
<tr>
<td>(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:</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>(i) Community living services provider agency;</td>
<td>• Nutritional Plan</td>
</tr>
<tr>
<td>(ii) Private duty nursing provider agency;</td>
<td>◦ Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan.</td>
</tr>
<tr>
<td>(iii) Adult habilitation provider agency;</td>
<td>◦ Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan.</td>
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<tr>
<td>(iv) Community access provider agency; and</td>
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<tr>
<td>(v) Supported employment provider agency.</td>
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<tr>
<td>(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</td>
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<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</td>
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<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
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consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. 
(c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. 
(d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). 
(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, 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.


CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

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

   (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010
F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
<table>
<thead>
<tr>
<th>Tag # 1A27 Incident Mgt. Late and Failure to Report</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: A. Duty To Report: (1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. (2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include: (a) an environmental hazardous condition, which creates an immediate threat to life or health; or (b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. (3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division’s website, <a href="http://dhi.health.state.nm.us/elibrary/ironline/ir.php">http://dhi.health.state.nm.us/elibrary/ironline/ir.php</a> or may be obtained from the department by calling the toll free number. Based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 3 of 13 individuals. Individual #3 • Incident date 6/14/2012 Allegation was Neglect. Incident report was received 6/15/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.” Individual #12 • Incident date 7/11/2012. Allegation was Emergency Services. Incident report was received 7/11/2012. IMB issued a Failure to Report for Emergency Services. Individual #13 • Incident date 3/30/2013. Allegation was Emergency Services. Incident report was received 4/2/2013. IMB issued a Late Reporting for Emergency Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Tag # 1A31</td>
<td>Standard Level Deficiency</td>
<td>Provider:</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Client Rights/Human Rights</td>
<td>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: → Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>
Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

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

**A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS**

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

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

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual’s Individual Service Plan.
Disabilities Supports Division (DDSD) - 
Procedure Title: Medication Assessment and Delivery 
Procedure Eff Date: November 1, 2006
B. 1. e. If the PRN medication is to be used in
response to psychiatric and/or behavioral
symptoms in addition to the above
requirements, obtain current written consent
from the individual, guardian or surrogate
health decision maker and submit for review by
the agency's Human Rights Committee
(References: Psychotropic Medication Use
Policy, Section D, page 5 Use of PRN
Psychotropic Medications; and, Human Rights
Committee Requirements Policy, Section B,
page 4 Interventions Requiring Review and
Approval – Use of PRN Medications).
### Tag # 6L13
Community Living Healthcare Reqts.

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 11 individuals receiving Community Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>• <strong>Dental Exam/Oral Screening</strong></td>
<td></td>
</tr>
<tr>
<td>○ Individual #10 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Vision Exam</strong></td>
<td></td>
</tr>
<tr>
<td>○ Individual #5 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
<td></td>
</tr>
</tbody>
</table>

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

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 6L25</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Health and Safety (SL/FL)</td>
<td>Based on observation, the Agency did not ensure that each individual’s residence met all requirements within the standard for 3 of 5 Supported Living residences.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</strong></td>
<td><strong>L. Residence Requirements for Family Living Services and Supported Living Services</strong></td>
<td><strong>Provider:</strong>&lt;br&gt;Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</td>
<td><strong>Supported Living Requirements:</strong></td>
<td></td>
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<tr>
<td>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</td>
<td>• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 8, 10, 11)</td>
<td></td>
</tr>
<tr>
<td>(b) General-purpose first aid kit;</td>
<td>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP (#1, 5, 11)</td>
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<tr>
<td>(c) When applicable due to an individual’s health status, a blood borne pathogens kit;</td>
<td>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#8, 10)</td>
<td></td>
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<tr>
<td>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</td>
<td><strong>Note:</strong> Individuals #1 and 11 and Individuals #8 and 10 share a residence.</td>
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<td>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</td>
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<td>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</td>
<td></td>
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<tr>
<td>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and</td>
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<td></td>
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<tr>
<td>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</td>
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</tbody>
</table>

Survey Report #: Q.13.4/DDW.D0612.4.001.RTN.01.204
Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Date Due
--- | --- | --- | ---

**Service Domain: Medicaid Billing/Reimbursement** – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

**TAG #1A12**

All Services Reimbursement (No Deficiencies Found)


Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION

B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

1. Date, start and end time of each service encounter or other billable service interval;
2. A description of what occurred during the encounter or service interval; and
3. The signature or authenticated name of staff providing the service.

Billing for Community Living (Supported Living and Independent Living) and Community Inclusion (Adult Habilitation, Community Access and Supported Employment) services was reviewed for 11 of 11 individuals. Progress notes and billing records supported billing activities for the months of February, March and April 2013.
Date: October 21, 2013

To: Donna Hooten, Executive Director

Provider: LEADERS Industries
Address: 115 W. Dunnam
State/Zip: Hobbs, New Mexico 88240

E-mail Address: dhooten@leadersind.com

CC: Bill Morrill, Board Chair
E-Mail Address bmorrill1952@yahoo.com

Region: Southeast
Survey Date: June 10 – 14, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)
Survey Type: Routine

Dear Ms. Hooten;

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

**Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.**

The Quality Management Bureau will need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

After reviewing the documentation submitted through your Plan of Correction, the following items are still outstanding:

- Tag 6L14
  - Nutritional Plans (#9 & 10) - Documentation provided stated that nutritional plans were being mailed by the company on October 7, 2013. These plans should now be available in your client files.

- Tag 1A20
  - The expectation for missing or out of date trainings is that they are completed prior to the end of the Plan of Correction (POC) or within a reasonable amount of time. The date of your survey was June 10-14, 2013, the Plan of Correction was originally scheduled to close September 25, 2013. Some of the trainings that were missing or out of date were not scheduled until the end of October. These timelines are not acceptable. No evidence the following trainings were completed was provided:
    - Foundation for Health and Wellness (DSP #47, 48, 57, 84)
    - Person-Centered Planning (1-Day) (DSP #43, 47, 51, 57, 67, 72, 86)
• First Aid (DSP #59, 78)
• CPR (DSP #59, 78)
• Participatory Communication and Choice Making (DSP #51, 55, 57, 78, 82, 84, 87)
• Positive Behavior Supports Strategies (DSP #57)
• Teaching and Support Strategies (DSP #51, 57)

• Tag 1A36
  o Pre-Service Manual (SC#94)

• Tag 1A03
  o Again, documentation provided does not include all required information to be considered a Continuous Quality Improvement Plan (CQI). Please refer back to the Standards (Chapter 1 I. Provider Agency Enrollment Process. I. Continuous Quality Management System).
  o Your Plan of Correction is not your Agency’s CQI Plan. Although the strategies discussed within your POC should be incorporated into your CQI Plan, the CQI Plan is an overall Quality Assurance Plan for your agency; the POC only highlights certain elements of that. If you need assistance developing this Plan please contact your Regional Office.

• Tag 1A15.2 & 5I09
  o Nutritional Plans (#9 & 10) - Documentation provided stated that nutritional plans were being mailed by the company on October 7, 2013. These plans should now be available in your client files.
    ▪ Please be able to provide verification these plans have made it into the homes.

• Tag 6L25
  o Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP (#1, 5, 11)
    ▪ The issue was not having this policy/procedure in place but the fact that it was not available at your residences. Please be able to provide verification this plan has been place in your homes.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, your case will be referred to the Internal Review Committee for discussion of possible civil monetary penalties possible monetary fines and/or other sanctions

Thank you for your cooperation with the Plan of Correction process.
Sincerely,

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