Dear Ms. Silva;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the Routine Survey on December 1 - 8, 2014. In addition, agency policy and procedures, medical follow up and health care documentation were also reviewed to verify compliance with the Developmental Disabilities Standards and Regulations.

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

**Compliance with Conditions of Participation.**

However, due to the new/repeat standard level deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up. You are also required to continue your Plan of Correction. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

**Plan of Correction:**
The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency’s verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance;
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future;
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

1. Quality Management Bureau, Attention: Plan of Correction Coordinator
   1170 North Solano Suite D Las Cruces, New Mexico 88001

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

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

Please call the Plan of Correction Coordinator at 575-373-5716, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Amanda Castañeda, MPA
Amanda Castañeda, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: August 4, 2015

Present: Lessons of Life, LLC
Rey Romero, Member Manager
Kami Silva, Director

DOH/DHI/QMB
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor

Exit Conference Date: August 5, 2015

Present: Lessons of Life, LLC
Emma Lozoya, RN
Kami Silva, Director
Leslie Fierro, Quality Assurance/Training Coordinator
Maya Barela, Service Coordinator
Leanne Thais, Scheduling/Hiring Rep Payee
Valerie Rodriguez, Timesheet Coordinator
Leonora Martinez, Nursing Assistant

DOH/DHI/QMB
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor

DDSD - SW Regional Office
Jeana Caruthers, Southwest Regional Director

Administrative Locations Visited Number: 1

Total Sample Size Number: 30

- 5 - Jackson Class Members
- 25 - Non-Jackson Class Members
- 10 - Supported Living
- 11 - Family Living
- 1 - Independent Living
- 1 - Adult Habilitation
- 4 - Community Access
- 1 - Supported Employment
- 12 - Customized Community Supports
- 6 - Community Integrated Employment Services
- 6 - Customized In-Home Supports

Persons Served Records Reviewed Number: 30

Direct Support Personnel Records Reviewed Number: 153 (Note: 1 DSP is also a Service Coordinator)

Substitute Care/Respite Personnel Records Reviewed Number: 26

Service Coordinator Records Reviewed Number: 4 (Note: 1 DSP is also a Service Coordinator)
Administrative Processes and Records Reviewed:

- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information

- Staff Training Records
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Quality Assurance / Improvement Plan

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

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

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

The QMB Determination of Compliance process is based on 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.
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](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, Tony Fragua at Anthony.Fragua@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: Lessons of Life, LLC - Southeast and Southwest Region
Program: Developmental Disabilities Waiver
Service: 2012: Living Supports (Supported Living, Family Living); Inclusion Supports (Customized Community Supports, Community Integrated Employment Services) and Other (Customized In-Home Supports)
2007: Community Living (Supported Living, Family Living, Independent Living) and Community Inclusion (Adult Habilitation, Community Access, Supported Employment)

Monitoring Type: Routine Survey
Survey Date: December 1 - 8, 2014
Verification Survey: August 4 – 5, 2015

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

**Tag # 1A27 Incident Mgt. Late and Failure to Report**

**NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS**

**NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:**

**A. Duty to report:**
(1) All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.
(2) All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI)

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Repeat / New Finding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 15 of 40 individuals.</td>
<td></td>
</tr>
<tr>
<td>Repeat / New Finding: 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 6 of 42 individuals.</td>
<td></td>
</tr>
</tbody>
</table>

Individual #5
- Incident date 5/5/2014. Allegation was Neglect. Incident report was received on 5/5/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”

Individual #19
- Incident date 6/2/2014. Allegation was Neglect. Incident report was received on 6/20/2014.

Individual #5
- Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 3/20/2015. IMB issued a Late Reporting for Neglect.

Individual #19
- Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 1/29/2015. IMB issued a Late Reporting for Neglect.
C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:

1. Abuse, neglect, and exploitation, suspicious injury or death reporting: Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an alleged case of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division’s abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll-free hotline number, 1-800-445-6242.

2. Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division’s hotline as required in Paragraph (2) of Subsection A of

<table>
<thead>
<tr>
<th>Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incident date 6/2/2014. Allegation was Exploitation. Incident report was received on 6/20/2014. Failure to Report. IMB Late and Failure Report indicated incident of Exploitation was “Unconfirmed.”</td>
</tr>
<tr>
<td>Individual #22</td>
</tr>
<tr>
<td>1. Incident date 11/27/2013. Allegation was Abuse, Neglect, and Exploitation. Incident report was received on 12/2/2013. IMB issued a Late Reporting for Emergency Services.</td>
</tr>
<tr>
<td>Individual #25</td>
</tr>
<tr>
<td>1. Incident date 11/25/2013. Allegation was Abuse, Neglect, and Exploitation. Incident report was received on 12/16/2013. Failure to Report. IMB Late and Failure Report indicated incident of Abuse, Neglect, and Exploitation was “Unconfirmed.”</td>
</tr>
<tr>
<td>Individual #30</td>
</tr>
<tr>
<td>1. Incident date 1/23/2014. Allegation was Neglect. Incident report was received on 1/24/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
<tr>
<td>1. Incident date 2/17/2014. Allegation was Neglect. Incident report was received on 2/19/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
<tr>
<td>1. Incident date 3/14/2014. Allegation was Neglect. Incident report was received on 3/17/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
</tbody>
</table>

| Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 6/3/2015. IMB issued a Late Reporting for Neglect. |
| Individual #21 |
| 1. Incident date 11/17/2014. Allegation was Exploitation. Incident report was received on 12/8/2014. Late Reporting. IMB Late and Failure Report indicated incident of Exploitation was “Unconfirmed.” |
| Individual #34 |
| 1. Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 4/6/2015. IMB issued a Late Reporting for Neglect. |
| Individual #41 |
| 1. Incident date 2/16/2015. Allegation was Neglect. Incident report was received on 2/23/2015. IMB issued a Late Reporting for Neglect. |
| Individual #42 |
| 1. Incident date 7/4/2015. Allegation was Neglect. Incident report was received on 7/6/2015. IMB issued a Late Reporting for Neglect. |

Survey Report #: Q.16.1.DDW.46528083.3.VER.01.15.261

Page 10 of 18
### 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division’s abuse, neglect, and exploitation or report of death form consistent with the requirements of the division’s abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division’s abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.

### (3) Limited provider investigation: No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation.

### (4) Immediate action and safety planning: Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:

- **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;
- **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division’s direction, if necessary; and

<table>
<thead>
<tr>
<th>Individual #31</th>
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</thead>
<tbody>
<tr>
<td>- Incident date 12/9/2013. Allegation was Exploitation. Incident report was received on 12/9/2013. Failure to Report. IMB Late and Failure Report indicated incident of Exploitation was “Confirmed.”</td>
</tr>
<tr>
<td>- Incident date 4/24/2014. Allegation was Neglect. Incident report was received on 4/24/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
<tr>
<td>- Incident date 6/17/2014. Allegation was Neglect. Incident report was received on 6/30/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
<tr>
<td>- Incident date 6/17/2014. Allegation was Exploitation. Incident report was received on 6/30/2014. Late Reporting. IMB Late and Failure Report indicated incident of Exploitation was “Unconfirmed.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #32</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Incident date 12/20/2013. Allegation was Neglect. Incident report was received on 1/7/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #33</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Incident date unknown. Allegation was Neglect. Incident report was received on 10/30/2014. IMB issued a Late Reporting for Neglect.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #34</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Incident date 9/12/2014. Allegation was Neglect. Incident report was received on 9/15/2014. Late Reporting. IMB issued a Late Reporting for Neglect.</td>
</tr>
</tbody>
</table>
(c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057.

(5) **Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident.

(6) **Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer’s legal guardian or parent is notified of the alleged incident of abuse, neglect, or exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division’s investigative representative.

(7) **Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer’s case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any

<p>| Individual #35 | Incident date 6/26/2014. Allegation was Neglect and Environmental Hazard. Incident report was received on 6/27/2014. IMB issued a Failure to Report for Neglect and Environmental Hazard. |
| Individual #36 | Incident date 2/18/2014. Allegation was Neglect. Incident report was received on 2/18/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.” |
| Individual #37 | Incident date 9/12/2014. Allegation was Neglect. Incident report was received on 9/15/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.” |
| Individual #38 | Incident date 10/30/2014. Allegation was Abuse and Neglect. Incident report was received on 10/31/2014. IMB issued a Failure to Report for Abuse and Neglect. |
| Individual #39 | Incident date 4/6/2014. Allegation was Neglect. Incident report was received on 4/8/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.” |
| Individual #40 | Incident date 6/19/2014. Allegation was Abuse and Exploitation. Incident report was received on 6/19/2014. Failure to Report. IMB Late and |</p>
<table>
<thead>
<tr>
<th>Documentation is forwarded to a case manager or consultant.</th>
<th>Failure Report indicated incident of Abuse and Exploitation was “Unconfirmed.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8) <strong>Non-responsible reporter:</strong> Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation</td>
<td></td>
</tr>
</tbody>
</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.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Description</th>
<th>Standard of Care</th>
<th>Routine Survey Deficiencies December 1 – 4, 2014</th>
<th>Verification Survey New and Repeat Deficiencies August 4 - 5, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A08</td>
<td>Agency Case File</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>1A08.1</td>
<td>Agency Case File - Progress Notes</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
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<tr>
<td>1A32</td>
<td>Individual Service Plan Implementation</td>
<td>Condition of Participation Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>IS11</td>
<td>Reporting Requirements Inclusion Reports</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>IS22</td>
<td>SE Agency Case File</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>LS14</td>
<td>Residential Case File</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>LS17</td>
<td>Reporting Requirements (Community Living Reports)</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1A11.1</td>
<td>Transportation Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1A20</td>
<td>Direct Support Personnel Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1A22</td>
<td>Agency Personnel Competency</td>
<td>Condition of Participation Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1A26</td>
<td>Consolidated On-line Registry Employee Abuse Registry</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>1A28.1</td>
<td>Incident Mgt. System - Personnel Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
</tbody>
</table>

**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>Service Description</th>
<th>Level of Deficiency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A36</td>
<td>Service Coordination Requirements</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A37</td>
<td>Individual Specific Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
</tbody>
</table>

**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>Service Description</th>
<th>Level of Deficiency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>CQI System</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A06</td>
<td>Policy and Procedure Requirements</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A09</td>
<td>Medication Delivery Routine Medication Administration</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A15.2</td>
<td>IS09 / 5I09 Healthcare Documentation</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>1A27.2</td>
<td>Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A28.2</td>
<td>Incident Mgt. System - Parent/Guardian Training</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A29</td>
<td>Complaints / Grievances Acknowledgement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>1A33.1</td>
<td>Board of Pharmacy - License</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>LS13 / 6L13</td>
<td>Community Living Healthcare Reqs.</td>
<td>Condition of Participation Level Deficiency</td>
<td>Completed</td>
</tr>
<tr>
<td>LS25 / 6L25</td>
<td>Residential Health and Safety (SL/FL)</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Service Description</th>
<th>Level of Deficiency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS25 / 5I25</td>
<td>Community Integrated Employment Services / Supported Employment Reimbursement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>Tag # 5I36 Community Access Reimbursement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>Tag # IS30 Customized Community Supports Reimbursement</td>
<td>Standard Level Deficiency</td>
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</tr>
<tr>
<td>Tag # LS26 / 6L26 Supported Living Reimbursement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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</tr>
<tr>
<td>Tag # LS27 / 6L27 Family Living Reimbursement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
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<tr>
<td>Tag # 6L28 Independent Living Reimbursement</td>
<td>Standard Level Deficiency</td>
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<tr>
<td>Tag # IH32 Customized In-Home Supports Reimbursement</td>
<td>Standard Level Deficiency</td>
<td>Completed</td>
<td></td>
</tr>
</tbody>
</table>
Date: October 1, 2015

To: Kami Silva, Director

Provider: Lessons of Life, LLC
Address: 421 Avenida De Mesilla, Suite D
State/Zip: Las Cruces, New Mexico 88005

E-mail Address: ksilva@lessonsoflifellc.com

CC: Eddie Ruiz and Rey Romero
E-Mail Address: eruiz@lessonsoflifellc.com; RRomero@lessonsoflifellc.com

Region: Southeast and Southwest
Routine Survey: December 1 - 8, 2014
Verification Survey: August 4 – 5, 2015
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Supported Living, Family Living); Inclusion Supports
(Customized Community Supports, Community Integrated Employment Services) and Other
(Customized In-Home Supports) 2007: Community Living (Supported Living, Family Living,
Independent Living) and Community Inclusion (Adult Habilitation, Community Access,
Supported Employment)

Survey Type: Verification

Dear Ms. Silva;

The Division of Health Improvement/Quality Management Bureau has received, reviewed and
approved the supporting documents you submitted for your Plan of Correction. The documents
you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

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

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

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

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

Amanda Castañeda
Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.16.1.DDW.46528083.3.VER.01.15.274