Date: January 30, 2014

To: Evangeline Zamora, Chief Executive Officer
Provider: Life Quest, Inc.
Address: 907 Pope St.
State/Zip: Silver City, New Mexico 88061
E-mail Address: ezamora@lifequestnm.org
dfrasca@lifequestnm.org

CC: Dr. Richard F. Rodriguez, Ph.D., Board Chair
E-mail Address: rodriguezrf@zianet.com

Region: Southwest
Survey Date: December 9 - 11, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Family Living) and Community Inclusion Supports (Adult Habilitation, Supported Employment)
Survey Type: Routine
Team Leader: Amanda Castañeda, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Cynthia Nielsen, MSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; and Deb Russell, BS Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Zamora;

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

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

Partial Compliance with Conditions of Participation

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

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

Survey Report #: Q.14.2.DDW.D1036.3.001.RTN.01.030
**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 505-231-7436 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,

*Amanda Castañeda, MPA*

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

---

Survey Report #: Q.14.2.DDW.D1036.3.001.RTN.01.030
Survey Process Employed:

Entrance Conference Date: December 9, 2013

Present: **Life Quest, Inc.**
Evangeline Zamora, Chief Executive Officer
Debra Frasca, Chief Operating Officer
Joseph Jensen, Human Resources Director

**DOH/DHI/QMB**
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor

Exit Conference Date: December 11, 2013

Present: **Life Quest, Inc.**
Evangeline Zamora, Chief Executive Officer
Debra Frasca, Chief Operating Officer
Rod Chandler, Special Services

**DOH/DHI/QMB**
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor

**DDSD - SW Regional Office**
Scott Doan, SW Regional Office Manager, via phone

Administrative Locations Visited Number: 1

Total Sample Size Number: 5

- 0 - *Jackson* Class Members
- 5 - Non-*Jackson* Class Members
- 2 - Family Living
- 4 - Adult Habilitation
- 2 - Supported Employment

Total Homes Visited Number: 2

- Family Living Homes Visited Number: 2

Persons Served Records Reviewed Number: 5

Persons Served Interviewed Number: 3

Persons Served Observed Number: 2 (One Individual was ill during the on-site survey and not seen and one Individual was asleep during the home visit)

Direct Support Personnel Interviewed Number: 6

Direct Support Personnel Records Reviewed Number: 27

Substitute Care/Respite Personnel Records Reviewed Number: 34
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 deficiencies and non-compliance.

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-231-7436 or email at Anthony.Fragua@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD 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 six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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
The following details should be considered when developing your Plan of Correction:

- 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, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans 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 indicators; 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 POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
   a. Electronically at Anthony.Fragua@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 “approved” 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.
   e. Please note that all POC correspondence will be sent electronically unless otherwise
      requested.
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. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to
   CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI),
   the preferred method is that you submit your documents 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. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and
   adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of
   Findings. In addition to this, we ask that you submit:
   a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals
      and timeframes of your choosing to verify POC implementation;
   b. Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC. to correct all
      unjustified units identified and submitted for payment 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 Plan of Correction Coordinator, prior to the due date and are approved on a
case-by-case basis. No changes may be made to your POC or the timeframes for implementation
without written approval of the POC Coordinator.
Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

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

The QMB Determination of Compliance process is based on 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.
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.
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, Crystal Lopez-Beck at crystal.lopez-beck@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.
## Standard of Care - Deficiencies

**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>Agency Case File</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| 1A08  | Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 5 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
- **ISP Teaching and Support Strategies**  
  - Individual #4 - TSS not found for the following Action Steps:  
    - (Work/Learn) "Will complete 3 work tasks within a contract independently"  
    - "Will complete each task."  
- **Positive Behavioral Crisis Plan (#5)**  
- **Occupational Therapy Plan (#5)** | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → | |
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 # 1A32 and 6L14</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Service Plan Implementation</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency 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 4 of 5 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: <strong>Administrative Files Reviewed:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>Individual #2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• None found regarding: &quot;...will be primed to choose attendance days for the gym&quot; for 8/2013 - 10/2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• None found regarding: &quot;...will receive a Decision Buck when she responds or engages in the targeted behavior&quot; for 8/2013 - 10/2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• &quot;Will complete her work assignment&quot; is to be completed 1 time per week. Action Step</td>
<td></td>
</tr>
</tbody>
</table>

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>Individual #4</th>
<th>“Will choose and attend a craft activity” is to be completed one time per month. Action Step was not being completed at the required frequency for 8/2013 and 9/2013.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #5</td>
<td>“Will find out the cost of the project he wants to work on and be sure he has the money to spend” is to be completed 2 times per month. Action Step was not being completed at the required frequency for 9/2013.</td>
</tr>
<tr>
<td></td>
<td>“Will purchase the items and will work on the same project until he finishes it” is to be completed 1 time per month. Action Step was not being completed at the required frequency for 9/2013.</td>
</tr>
</tbody>
</table>

**Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

<table>
<thead>
<tr>
<th>Individual #4</th>
<th>“Will use a check list for each task” is to be completed 1 time per week. Action Step was not being completed at the required frequency for 9/2013.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #5</td>
<td>Review of Agency’s documented Outcomes and Action Steps do not match the current ISP (2/20/13 – 2/19/14) Outcomes and Action Steps for Work/Learn.</td>
</tr>
</tbody>
</table>

**Residential Files Reviewed:**
Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #2

- None found regarding: “Will receive a shopping list of items twice a week” for 12/1 – 9, 2013.

- None found regarding: “Staff will go into the community to purchase listed items twice a week” for 12/1 – 9, 2013.

- None found regarding: “Will choose each item from the list per requirements twice a week” for 12/1 – 9, 2013.

- None found regarding: “With assistance will make the purchase and return the items back home twice a week” for 12/1 – 9, 2013.
<table>
<thead>
<tr>
<th>Tag # 5I11.1 Reporting Requirements (CI Report Components)</th>
<th>Standard Level Deficiency</th>
<th></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 1 of 5 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: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP; (3) Significant changes in the individual’s routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>Individual #3 - The following components were not found in the Adult Habilitation Quarterly Report for 3/2013 - 6/2013:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>(1) Documentation summarizing the following: (a) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) 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>
<td></td>
</tr>
<tr>
<td><strong>Tag # 5I22 SE Agency Case File</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td>Based on record review, the Agency did not maintain a confidential case file for each individual receiving Supported Employment Services for 2 of 2 individuals.</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. Provider Agency Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual’s earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual’s earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Quarterly progress reports;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person’s interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider:</strong></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td><strong>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</strong></td>
<td>→</td>
<td></td>
</tr>
</tbody>
</table>

Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and

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

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

II. POLICY STATEMENT
Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.
<table>
<thead>
<tr>
<th>Tag # 6L14 Residential Case File</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 a complete and confidential case file in the residence for 2 of 2 Individuals receiving Family Living Services.</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>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td><strong>A. Residence Case File:</strong> For individuals receiving Supported 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>- <strong>Current Emergency and Personal Identification Information</strong>&lt;br&gt;  ° None Found (#3)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>(1) Complete and current ISP and all supplemental plans specific to the individual;</td>
<td>- Individual Specific Training Section of ISP (formerly Addendum B) (#2)</td>
<td></td>
</tr>
<tr>
<td>(2) Complete and current Health Assessment Tool;</td>
<td>- Physical Therapy Plan (#2)</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>
<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>
<td></td>
</tr>
<tr>
<td>(5) Data collected to document ISP Action Plan implementation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(6) Progress notes written by direct care staff 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.

(10) 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

(11) 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.
**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>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A11.1</td>
<td>Based on record review, 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 2 of 27 Direct Support Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here:  →</td>
</tr>
</tbody>
</table>

**Tag # 1A11.1 Transportation Training**


**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...

G. Transportation: Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, with comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled “Client Transportation Safety”.

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 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 1 of 27 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</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>C. Orientation and Training Requirements:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>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></td>
<td>→</td>
<td></td>
</tr>
<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 1, 2007 - II. POLICY STATEMENTS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A22 Agency Personnel Competency</td>
<td>Standard Level Deficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on interview, the Agency did not ensure training competencies were met for 4 of 6 Direct Support Personnel.</td>
<td></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>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DSP #55 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index. (Individual #2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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;</td>
<td>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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DSP #42 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Falls. (Individual #4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DSP #55 stated, “No.” The Individual Specific Training section of the ISP indicates the Individual requires a Medical Emergency Response Plan for Seasonal Allergies. (Individual #2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>When DSP were asked if they received training on the Individual’s Meal Time Plans and what the plan covered, the following was reported:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DSP #45 stated, “He just has a MERP.” According to the Health &amp; Safety Section of</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
<td></td>
</tr>
<tr>
<td></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>
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.

the ISP, it is indicated the individual has a Meal Time Plan. (Individual #3)

- DSP #56 stated, “No.” According to the Health & Safety Section of the ISP, it is indicated the individual has a Meal Time Plan. (Individual #3)
<table>
<thead>
<tr>
<th>Tag # 1A25</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Caregiver History Screening</td>
<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 2 of 63 Agency Personnel. The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</td>
</tr>
</tbody>
</table>

**Substitute Care/Respite Personnel:**
- #90 – Date of hire 9/22/2003.

**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 7.1.9.8 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. |

| 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. |

| 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;

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>Consolidated On-line Registry Employee Abuse Registry</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.12.8 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.</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 2 of 63 Agency Personnel. The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Direct Support Personnel (DSP):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>• #50 – Date of hire 10/30/2012, completed 12/7/2012.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as</td>
<td>• #66 – Date of hire 6/10/2013, completed 6/12/2013.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 # 1A28.1</th>
<th>Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</strong></td>
<td>Based on record review, the Agency did not ensure Incident Management Training for 2 of 29 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td><strong>A. General:</strong> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>D. Training Documentation:</strong> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee’s employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</td>
<td>• Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP# 56, 63)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Policy Title:</strong> Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>II. POLICY STATEMENTS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
<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><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 2 of 29 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</strong> 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>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td><strong>C. Orientation and Training Requirements:</strong> 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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) <strong>Individual-specific training</strong> 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><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>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:</strong></td>
<td>• Individual Specific Training (DSP #50, 66)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td><strong>Provider:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard of Care</td>
<td>Deficiencies</td>
<td>Agency Plan of Correction, On-going QA/QI and Responsible Party</td>
<td>Date Due</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>---------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Service Domain: Health and Welfare</strong> – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tag # 1A05</strong> General Provider Requirements</td>
<td><strong>Standard Level Deficiency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPER 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. A. General Requirements: (2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.</td>
<td>Based on record review, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures. Review of Agency policies and procedures found the following: The following policies and procedures showed no evidence of being reviewed every three years or being updated as needed: • “Transportation” - Last reviewed 3/2005. • “Medication Assistance and Delivery” - Last reviewed 2/2009. • “Medication Errors” - Last reviewed 2/2009. • “Storage of Medication” - Last reviewed 4/2010. • “Individual Funds/Representative Payee” - Last reviewed 1/2010.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>
Tag # 1A09
Medication Delivery
Routine Medication Administration

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Records (MAR) were reviewed for the months of October, November and December 2013.</td>
</tr>
<tr>
<td>Based on record review, 2 of 5 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
</tr>
<tr>
<td>Individual #3</td>
</tr>
<tr>
<td>October 2013</td>
</tr>
</tbody>
</table>
| Medication Administration Record did not contain the specific time the medication should be given and/or specific time it was assisted with. MAR indicated time as “Bedtime”:

- Latanoprost (1 time daily) |
| November 2013 |
| Medication Administration Record did not contain the specific time the medication should be given and/or specific time it was assisted with. MAR indicated time as “Bedtime”:

- Latanoprost (1 time daily) |
| December 2013 |
| Medication Administration Record did not contain the specific time the medication should be given and/or specific time it was assisted with. MAR indicated time as “Bedtime”:

- Latanoprost (1 time daily) |

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: →
and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for 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.
<table>
<thead>
<tr>
<th>Tag # 1A09.1</th>
<th>Medication Delivery PRN Medication Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Level Deficiency</strong></td>
<td>Medication Administration Records (MAR) were reviewed for the months of October, November and December, 2013. Based on record review, 1 of 5 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #5 October 2013 Review of daily notes and staff interview (DSP #46) indicated “staff assisted with noon meds.” When asked what medication was given at noon, staff stated “Pro Air for respiratory.” Per documentation reviewed, Pro Air is a PRN medication. The following medication was not documented on the Medication Administration Records: • Pro Air Inhaler (PRN) November 2013 Review of daily notes and staff interview (DSP #46) indicated “staff assisted with noon meds.” When asked what medication was given at noon, staff stated “Pro Air for respiratory.” Per documentation reviewed, Pro Air is a PRN medication The following medication was not documented on the Medication Administration Records: • Pro Air Inhaler (PRN)</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: →

---


Survey Report #: Q.14.2.DDW.D1036.3.001.RTN.01.030
and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for 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:**

- 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.).
Tag # 1A15.2 and 5I09
Healthcare Documentation

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
</tr>
<tr>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>- Medical Emergency Response Plans</td>
</tr>
<tr>
<td>- Gastrointestinal</td>
</tr>
<tr>
<td>- Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
</tbody>
</table>

Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 5 individual

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:


Survey Report #: Q.14.2.DDW.D1036.3.001.RTN.01.030
Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

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

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

(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, 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</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Mgt. Late and Failure to Report</td>
<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 4 of 9 individuals. Individual #6</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>7.1.1.3.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Duty To Report:</td>
<td>Individual #6</td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td>Incident date 12/19/2012. Allegation was Emergency Services. Incident report was received 12/31/2012. IMB issued a Late Reporting for Emergency Services.</td>
<td></td>
</tr>
<tr>
<td>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 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 4 of 9 individuals.</td>
<td>Incident date 1/4/2013. Allegation was Neglect. Incident report was received 1/8/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incident date 11/25/2012. Allegation was Emergency Services. Incident report was received 12/3/2012. IMB issued a Late Reporting for Emergency Services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incident date 1/4/2013. Allegation was Neglect. Incident report was received 1/8/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incident date 1/4/2013. Allegation was Neglect. Incident report was received 1/8/2013. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Individual #9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident date 1/4/2013. Allegation was Law Enforcement Involvement. Incident report was received 1/9/2013. IMB issued a Failure to Report for Law Enforcement Involvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 6L06</td>
<td>Standard Level Deficiency</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Family Living Requirements</strong></td>
<td><strong>Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 2 of 5 individuals.</strong></td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Review of the Agency files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monthly Consultation with the Direct Support Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Individual #2 - None found for 5/2013, 6/2013, 7/2013, and 10/2013.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Individual #3 - None found for 5/2013, 6/2013, and 7/2013.</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</strong></td>
<td><strong>Provider:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A. Support to Individuals in Family Living:</strong> The Family Living Services Provider Agency shall provide and document:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) Review, advise, and prompt the implementation of the individual’s ISP Action Plans, schedule of activities and appointments; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.</td>
<td></td>
</tr>
<tr>
<td><strong>B. Home Studies.</strong> The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.14.2.DDW.D1036.3.001.RTN.01.030

Page 54 of 61
Service Standards effective 4/1/2007

CHAPTER 1. I. PROVIDER AGENCY
ENROLLMENT PROCESS

D. Scope of DDSD Agreement

(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;

NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER

ELIGIBLE PROVIDERS:

I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.

1. Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.
<table>
<thead>
<tr>
<th>Tag # 6L13</th>
<th>Community Living Healthcare Reqs.</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Living Healthcare Reqs.</td>
<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 1 of 2 individuals receiving Community Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
</tbody>
</table>
|           | G. Health Care Requirements for Community Living Services. | - **Auditory Exam**  
  ° Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 11/28/2011. Follow-up was to be completed annually. No evidence of follow-up found. | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
|           | (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: | | |

---


Survey Report #: Q.14.2.DDW.D1036.3.001.RTN.01.030
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).
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.
**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 (Family Living) and Community Inclusion (Adult Habilitation and Supported Employment) services was reviewed for 5 of 5 individuals. *Progress notes and billing records supported billing activities for the months of August, September, and October 2013.*
Date: April 1, 2014

To: Evangeline Zamora, Chief Executive Officer
Provider: Life Quest, Inc.
Address: 907 Pope St.
State/Zip: Silver City, New Mexico 88061
E-mail Address: ezamora@lifequestnm.org
dfrasca@lifequestnm.org
CC: Dr. Richard F. Rodriguez, Ph.D., Board Chair
E-Mail Address rodriuezrf@zianet.com
Region: Southwest
Survey Date: December 9 - 11, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Family Living) and Community Inclusion Supports (Adult Habilitation, Supported Employment)
Survey Type: Routine

Dear Ms. Zamora:

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,

Tony Fragua