Dear Ms. Dahl-Nunn,

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

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

**Compliance with all Conditions of Participation.**

This determination is based on your agency’s compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.
Plan of Correction:
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency’s compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

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

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

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

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

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

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

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

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

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

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

Sincerely,

Valerie V. Valdez, M.S.

Valerie V. Valdez, M.S.
Healthcare Program Manager
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: 10/22/2012

Present:

**The New Beginnings, LLC**
- Ken Sangha, Operations Manager
- Diane Dahl Nunn, Executive Director

**DOH/DHI/QMB**
- Mari Chavez, BSW, Team Lead/Healthcare Surveyor
- Cynthia Nielsen, MSN, RN, Healthcare Surveyor
- Jennifer Bruns, BSW, Healthcare Surveyor
- Erica Nilsen, BS, Healthcare Surveyor
- Tony Fragua, BFA, Healthcare Surveyor
- Nicole Brown, MBA, Healthcare Surveyor

Exit Conference Date: 10/25/2012

Present:

**The New Beginnings, LLC**
- Diane Dahl Nunn, Executive Director
- Ken Sangha, Operations Manager
- Kelley Krinke, Service Coordinator Supervisor
- Desiree Martinez, Director of Nursing
- Matthew Crawforth Service Coordinator
- Shannon Hogue, Service Coordinator

**DOH/DHI/QMB**
- Mari Chavez, BSW, Team Lead/Healthcare Surveyor
- Erica Nilsen, BS, Healthcare Surveyor
- Deb Russell, BS, Healthcare Surveyor
- Nicole Brown, MBA, Healthcare Surveyor
- Cynthia Nielsen, MSN, RN, Healthcare Surveyor

Total Homes Visited
- Number: 25
  - Supported Homes Visited: 9
  - Family Homes Visited: 16

Administrative Locations Visited
- Number: 1

Total Sample Size
- Number: 27
  - Jackson Class Members: 2
  - Non-Jackson Class Members: 25
  - Supported Living: 9
  - Family Living: 16
  - Independent Living: 2
  - Adult Habilitation: 12
  - Community Access: 4

Persons Served Records Reviewed
- Number: 27

Persons Served Interviewed
- Number: 14

Persons Served Observed
- Number: 13 (5 Individuals did not want to participate in the interview, 5 Individuals did not respond to surveyors' questions and 3 Individuals were not available during the on-site survey)
Direct Support Personnel Interviewed Number: 37
Direct Support Personnel Records Reviewed Number: 237
Service Coordinator Records Reviewed Number: 8

Administrative Files Reviewed

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

CC: Distribution List:

DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
DOH - Internal Review Committee
Attachment A

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

The following details should be considered when developing your POC:

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

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

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

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

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

6. QMB will notify you when your POC has been “approve” or “denied.”
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.

b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.

c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.

d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

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

**POC Document Submission Requirements**

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.

2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).

3. All submitted documents must be annotated; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.

4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.

5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.

6. For billing deficiencies, you must submit:
   a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
   b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Deputy Chief at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.
Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

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

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.
Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

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

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

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

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

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

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

Agency: The New Beginnings, LLC - Metro, Northwest and Southwest Regions  
Program: Developmental Disabilities Waiver  
Service: Community Living Supports (Supported Living, Family Living, Independent Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)  
Monitoring Type: Routine Survey  
Date of Survey: October 22 - 26, 2012

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| **CMS Assurance – Service Plans: ISP Implementation** – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan. | Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 5 of 27 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
- **Current Emergency & Personal Identification Information**  
  ° Did not contain Health Plan Information (#3)  
- ISP Signature Page (#2, 18)  
- Occupational Therapy Plan (#24)  
- Documentation of Guardianship/Power of Attorney (#6)  
- Transition Plan (#2) | Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: → | |
or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;

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

(3) Progress notes and other service delivery documentation;

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

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

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

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

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

(a) Complete file for the past 12 months;

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

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

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

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

**B. Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1 Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 3 of 27 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Adult Habilitation Progress Notes/Daily Contact Logs</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:</td>
<td>Community Access Progress Notes/Daily Contact Logs</td>
<td></td>
</tr>
<tr>
<td>(3) Progress notes and other service delivery documentation;</td>
<td>• Individual #1 - None found for 8/20, 21, 22, 28, 29, 30 and 9/18, 26, 27, 2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Individual #5 - None found for 7/23 - 31, 2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Individual #9 – None found for 9/16 – 29, 2012.</td>
<td></td>
</tr>
<tr>
<td>Tag # 1A32 &amp; 6L14 ISP Implementation</td>
<td>Standard Level Deficiency</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</strong> 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.</td>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 27 individuals.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes: <strong>Administrative Files Reviewed:</strong> Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Individual #25**

- Per Live Outcome; Action Step for: "...will *take* pictures," was not being completed at the required frequency. Documentation for 7/2012, 8/2012 and 9/2012 states, "Camera not working." No documentation found to indicate agency has addressed issue.

- Per Live Outcome; Action Step for: "...will *complete* pictures" was not being completed at the required frequency. Documentation for 7/2012, 8/2012 and 9/2012 states, "Camera not working." No documentation found to indicate agency has addressed issue.

- Per Live Outcome; Action Step for: "...will *share* pictures" was not being completed at the required frequency. Documentation for 7/2012, 8/2012 and 9/2012 states, "Camera not working." No documentation found to indicate agency has addressed issue.

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


Survey Report #: Q.13.2.DDW.1686680.2/3/5.001.RTN.1.042
The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

### Tracking/Progress with regards to ISP Outcomes:

- Individual #2
  - None found for 8/2012 - 9/2012.

- Individual #6
  - Per Live Outcome; Action Step for: “…will purchase a Karaoke machine,” were not completed at the required frequency for 7/2012 - 9/2012. Per data tracking sheet indicates individual cannot afford karaoke machine. No evidence found that agency addressed issue.

### Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

- Individual #6
  - None found for 7/2012 - 9/2012.

- Individual #7
  - None found for 7/2012 - 8/2012.

### Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

- Individual #9
  - None found for 8/2012 - 9/2012.

### Residential Files Reviewed:

### Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

- Individual #2
  - Per Live Outcome; Actions Steps for: “…will work on organizing and decorating,” is to be
completed 1 time per week, evidence found indicated it was not being completed at the required frequency indicated in the ISP for 10/1 – 19, 2012.

- Per Work Outcome; Actions Steps for “...will work on sewing project,” is to be completed 2 times per week evidence found indicated it was not being completed at the required frequency indicated in the ISP for 10/1 – 19, 2012.
## Tag # 6L14  Residential Case File

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 16 of 25 Individuals receiving Family Living Services and Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>- Annual ISP (#6, 11, 20, 25, 27)</td>
</tr>
<tr>
<td>- Individual Specific Training Section of ISP (#6, 11, 20, 25, 27)</td>
</tr>
<tr>
<td>- Positive Behavioral Plan (#4, 24)</td>
</tr>
<tr>
<td>- Speech Therapy Plan (#6)</td>
</tr>
<tr>
<td>- Occupational Therapy Plan (#20, 23, 24)</td>
</tr>
<tr>
<td>- Physical Therapy Plan (#6, 11)</td>
</tr>
</tbody>
</table>
| - Special Health Care Needs  
  - Nutritional Plan (#4, 14, 22, 27) |
| - Health Care Plans  
  - Body Mass Index (#3, 15)  
  - Hypertension (#21)  
  - Oral Care (#5, 12, 14)  
  - Osteoporosis (#21)  
  - Pain/Gastroesophageal Reflux Disease (#21)  
  - Protocol for refusal of insulin & food (#7) |
| - Crisis Plan/Medical Emergency Response Plans  
  - Allergies (#21) |

### 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: →

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(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:
   - The name of the individual;
   - A transcription of the healthcare practitioner’s prescription including the brand and generic name of the medication;
   - Diagnosis for which the medication is prescribed;
   - Dosage, frequency and method/route of delivery;
   - Times and dates of delivery;
   - Initials of person administering or assisting with medication; and
   - 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

- Cardiac Condition (#15)
- Gastrointestinal/ Gastroesophageal Reflux Disease (#21)
- Potential for violence (#7)
- Risk for Fractures (#21)

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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.
**Standard of Care** | **Deficiencies** | **Agency Plan of Correction, On-going QA/QI & Responsible Party** | **Date Due**
---|---|---|---

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

<table>
<thead>
<tr>
<th>Tag # 1A11.1 Transportation Training</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 3 of 237 Direct Support Personnel. When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:  
  - DSP #172 stated, “No. I have not.”  
  - DSP #47 stated, “I don’t think so, no.”  
  - DSP #143 stated, “I don’t remember.” |  |
|  | **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: → |  |

**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:**

1. 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

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<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>those who require physical assistance to enter/exit a vehicle)</td>
<td></td>
</tr>
<tr>
<td>5. Operating wheelchair lifts (if applicable to the staff's role)</td>
<td></td>
</tr>
<tr>
<td>6. Wheelchair tie-down procedures (if applicable to the staff's role)</td>
<td></td>
</tr>
<tr>
<td>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)</td>
<td></td>
</tr>
</tbody>
</table>
Tag # 1A20  Direct Support Personnel Training

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 21 of 237 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>
</tr>
<tr>
<td>- Pre- Service (DSP #72)</td>
</tr>
<tr>
<td>- Foundation for Health &amp; Wellness (DSP #72, 75, 78, 107, 261)</td>
</tr>
<tr>
<td>- Person-Centered Planning (1-Day) (DSP #107)</td>
</tr>
<tr>
<td>- First Aid (DSP #194, 212)</td>
</tr>
<tr>
<td>- CPR (DSP #194, 212, 268)</td>
</tr>
<tr>
<td>- Assisting With Medication Delivery (DSP #59, 127, 150, 167, 191, 194, 212, 223)</td>
</tr>
<tr>
<td>- Participatory Communication &amp; Choice Making (DSP #60, 65, 140, 243)</td>
</tr>
<tr>
<td>- Positive Behavior Supports Strategies (DSP #65, 159, 243)</td>
</tr>
<tr>
<td>- Teaching &amp; Support Strategies (DSP #65, 70, 133, 134, 140, 159)</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: →
March 1, 2007 - II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.
F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.
G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.
H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Agency Personnel Competency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on interview, the Agency failed to ensure that training competencies were met for 5 of 37 Direct Support Personnel.</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 they received training on the Individual's ISP and what the plan covered, the following was reported:</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>- DSP #117 stated, &quot;Not specifically on (#15)&quot; (Individual #15)</td>
<td></td>
</tr>
<tr>
<td>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</td>
<td>- DSP #219 stated, &quot;No.&quot; (Individual #6)</td>
<td></td>
</tr>
<tr>
<td>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;</td>
<td>When DSP were asked what type of Individual Specific Training they received on the Individual and what the training covered, the following was reported:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- DSP #117 stated, &quot;Not specifically for (#15) but her FLP trained me on how to handle her money and stuff.&quot; (Individual #15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- DSP #219 stated, &quot;No; just general, nothing specific to him. Just general CPR and medication.&quot; (Individual #6)</td>
<td></td>
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<tr>
<td></td>
<td>When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
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<tr>
<td></td>
<td>- DSP #172 stated, &quot;No, I don't.&quot; According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #25)</td>
<td></td>
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<tr>
<td></td>
<td>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s)</td>
<td></td>
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</tbody>
</table>


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(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

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

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:
(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;
(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and
(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy covered, the following was reported:

- DSP #117 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Weight/Body Mass Index (Individual #15)
- DSP #172 stated, “Yes, seizures and magnet for seizures.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Oral health. (Individual #25)

**When DSP were asked, what steps are you to take in the event of a medication error, the following was reported:**

- DSP #46 stated, “Call nurse, I would throw it away.” (Individual #4) Per Agency Medication Documentation Policy 807, “Staff will place medication(s) in a sealable plastic bag. Label the bag with the individual’s name, date or refusal/contamination, what medication is contained in the plastic bag. (This plastic bag is then to be placed in the discontinued/expired storage container.)”
- DSP #173 stated “Call nurse, throw it away, dispose of it.” (Individual #14) Per Medication Documentation Policy 807, “Staff will place medication(s) in a sealable plastic bag. Label the bag with the individual’s name, date or refusal/contamination, what medication is contained in the plastic bag. (This plastic bag is then to be placed in the discontinued/expired storage container.)”

When DSP were asked what the individual’s Diagnosis were, the following was reported:
| - 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.  
   • DSP #117 stated, “Just her cholesterol, she’s a little slow.” As indicated by collateral documentation reviewed the Individual is diagnosed with Heart Murmurs, Mild Mitral Regurgitation, Pulmonary Hypertension, Mild Mental Retardation and Hypercholesteremia. (Individual #15)  
   When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:  
   • DSP #117 stated, “Yes, Penicillin.” As indicated by the Individual Data form in Therap, the Individual has no allergies. (Individual #15) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A28.1 Incident Mgt. System - Personnel Training</td>
<td>Standard Level Deficiency</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td>Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 8 of 245 Agency Personnel.</td>
</tr>
</tbody>
</table>
| A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. | **Direct Support Personnel (DSP):**  
- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#90, 146, 191, 200, 211, 214, 253)  

When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:  
- DSP #219 stated, “I have it at the house, not with me.” Staff was not able to identify the two State Agencies as APS & DHI. |
| D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. | **Policy Title:** Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 |
| **II. POLICY STATEMENTS:**  
A. Individuals shall receive services from competent and qualified staff. | **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:  

}
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 1A37 Individual Specific Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 7 of 245 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of personnel records found no evidence of the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct Support Personnel (DSP):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Individual Specific Training (#73, 74, 128, 131, 142, 168, 261)</td>
<td></td>
</tr>
<tr>
<td>C. Orientation and Training Requirements:</td>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</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>A. Individuals shall receive services from competent and qualified staff.</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>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the</td>
<td></td>
</tr>
</tbody>
</table>


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specifications described in the individual service plan (ISP) of each individual served.
### CMS Assurance – Health and Welfare

The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>CQI System</td>
<td>Based on record review, the Agency has not fully implemented the Continuous Quality Management System as required by standard.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**Tag # 1A03 CQI System**


**CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS**

**I. Continuous Quality Management System:**

Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:

1. Individual access to needed services and supports;
2. Effectiveness and timeliness of implementation of Individualized Service Plans;
3. Trends in achievement of individual outcomes in the Individual Service Plans;
4. Trends in medication and medical incidents leading to adverse health events;

Review of the findings identified during the routine on-site survey October 22 – 26, 2012 and as reflected in this report of findings the Agency has multiple noted deficiencies.

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

[ ]
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;

(6) Quality and completeness documentation; and

(7) Trends in individual and guardian satisfaction.

### 7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:

#### E. Quality Improvement System for Community Based Service Providers:

The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

1. Community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;

2. Community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;

3. Community based service providers providing developmental disabilities...
services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A09</th>
<th>Medication Delivery (MAR) - Routine Medication</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td>Medication Administration Records (MAR) were reviewed for the months of August, September &amp; October 2012.</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER II. PROVIDER AGENCY REQUIREMENTS:</strong> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E. Medication Delivery:</strong> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
<td>Based on record review, 7 of 25 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</td>
<td></td>
</tr>
<tr>
<td>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</td>
<td>Individual #13 October 2012 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</td>
<td></td>
</tr>
<tr>
<td>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</td>
<td>• Sodium Bicarbonate (Vit D) (2 times daily)</td>
<td></td>
</tr>
<tr>
<td>(c) Initials of the individual administering or</td>
<td>Individual #19 September 2012 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
<td></td>
</tr>
<tr>
<td>Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:</td>
<td>• Vitamin D 1000 units (1 time daily) – Blank 9/29, 30 (8 AM)</td>
<td></td>
</tr>
<tr>
<td>• Acetaminophen 500 mg</td>
<td>Individual #20 August 2012 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
<td></td>
</tr>
<tr>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td>• Ziprasidone HCL 60 mg (1 time daily) – Blank 8/30 &amp; 31 (8 AM)</td>
<td></td>
</tr>
<tr>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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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:
(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;
   Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
   • Geodon 40mg (1 time daily)
   • Ziprasidone 60mg (1 time daily)
   • Ziprasidone HCL 40 mg (1 time daily)
   • Amitriptyline 50 mg (1 time daily)
   • Desmopressin 0.2mg (1 time daily)
   • Divalproex sodium 500 mg (1 time daily)
   • Dronabinol 5 mg (1 time daily)
   • Levothyroxine 5 mg (1 time daily)
   • Oxybutynin 5 mg (1 time daily)
   • Tri-sprintec (1 time daily)
   Medication Administration Record did not contain the time the medication should be given.
   • Cetirizine HCL 10 mg (1 time daily)

Individual #22
August 2012
Medication Administration Records did not contain the frequency of medication to be given:
• Greens Infusion

September 2012
Medication Administration Records did not contain the frequency of medication to be given:
• Greens Infusion
(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.

Individual #24
August 2012
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Citalopram 10 mg (1 time daily)

Individual #25
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Azithromycin 250 mg (1 time daily)

Medication Administration Records did not contain the route of administration for the following medications:
- Azithromycin 250 mg (1 time daily)

Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:
- Azithromycin 250 mg (1 time daily)

Individual #27
October 2012
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Lovastatin 10 mg (1 time daily)
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Medication Delivery - PRN Medication</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A09.1</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Medication Administration Records (MAR) were reviewed for the months of August, September and October 2012.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</strong> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Based on record review, 7 of 25 individuals had PRN Medication Administration Records, which contained missing elements as required by standard:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</td>
<td>Individual #7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
<td>August 2012</td>
<td>Provider:</td>
</tr>
<tr>
<td></td>
<td>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</td>
<td>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</td>
<td>• Ibuprofen 800 mg – PRN – 8/24, 25, 26, 27, 28 &amp; 30 (given 1 time)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Initials of the individual administering or</td>
<td>Medication Administration Records did not contain the circumstance for which the medication is to be used:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prazosin 5 mg (PRN)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Quetiapine Fumarate 50 mg (PRN)</td>
<td></td>
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<td></td>
<td></td>
<td>Individual #9</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>August 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</td>
<td>Provider:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrocodone 10 mg – PRN – 8/1, 3, 4, 5, 6, 7, 9, 10 (given 1 time)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hydrocodone 10 mg – PRN – 8/2 (given 2 times)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.2.DDW.1686880.2/3/5.001.RTN.1.042
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:

(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;

   "Hydrocodone 10 mg (PRN)"

   Medication Administration Records did not contain the exact amount to be used in a 24 hour period:

   "Hydrocodone 10 mg (PRN)"

   Individual #19

   September 2012

   Medication Administration Records do not indicate whether the following medications are Routine or PRN medications and do not include required information as per standard:

   "Acetaminophen 500 mg"

   No Time of Administration was noted on the Medication Administration Record for the following PRN medication:

   "Acetaminophen 500 mg - 9/10, 11, 15 (given 2 times)"

   No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

   "Acetaminophen 500 mg – 9/10, 11, 15 (given 2 times)"

   Individual #20

   August 2012

   Medication Administration Records did not contain the circumstance for which the medication is to be used:

   "Ducate 100 mg (PRN)"

   "Fexofenadine HCL 180 mg (PRN)"

   September 2012

   No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
(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.

- Fexofenadine HCL 180 mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 (given 1 time)

No Time of Administration was noted on the Medication Administration Record for the following PRN medication:

- Fexofenadine HCL 180 mg – PRN – 9/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 (given 1 time)

Individual #21
September 2012
Medication Administration Records did not contain the circumstance for which the medication is to be used:

- Acetaminophen 160 mg/5 ml (PRN)

Individual #24
August 2012
Medication Administration Records did not contain the circumstance for which the medication is to be used:

- Acetaminophen 325 mg (PRN)

September 2012
Medication Administration Records did not contain the circumstance for which the medication is to be used:

- Acetaminophen 325 mg (PRN)

Individual #25
August 2012
No Effectiveness was noted on the Medication Administration Record for the following PRN medication:

- Ibuprofen 400 mg – PRN – 8/21, 22, 26, 27, 30 (given 1 time)
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.

<table>
<thead>
<tr>
<th>September 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</td>
</tr>
<tr>
<td>• Ibuprofen 600 mg – PRN – 9/25, 27 (given 1 time)</td>
</tr>
<tr>
<td>• Loratadine 10 mg – PRN – 9/2, 4 (given 1 time)</td>
</tr>
<tr>
<td>• Risperidone 0.25 mg – PRN – 9/4, 8, 16, 17, 26 (given 1 time)</td>
</tr>
</tbody>
</table>

Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:

- Ibuprofen 600 mg (PRN)
- Loratadine 10 mg (PRN)
- Risperidone 0.25 mg – (PRN)
Department of Health Developmental Disabilities Supports Division (DDSD) -
Procedure Title:
Medication Assessment and Delivery
Procedure Eff Date: November 1, 2006

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

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

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
<table>
<thead>
<tr>
<th>Tag # 1A15.2 &amp; 5I09 - Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
<td>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 27 individual</td>
</tr>
<tr>
<td>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual’s Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 27 individual</td>
<td></td>
</tr>
</tbody>
</table>

Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:

- Electronic Comprehensive Health Assessment Tool (eChat) (#2)
- Medication Administration Assessment Tool (#2)
- Healthcare Passport (#2)
- Aspiration Risk Management Screening Tool (#2)
- Health Care Plans
  - Weight/Body Mass Index
  - Individual #2 – Per collateral documentation reviewed the Individual is required to have a plan. No evidence of a plan found.
  - Oral Care
  - Individual #2 - Per collateral documentation reviewed the Individual is required to have a plan. No evidence of a plan found.

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:
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
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.

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**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.
F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
<table>
<thead>
<tr>
<th>Tag # 1A27 Incident Mgt Late &amp; Failure to Report</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</td>
<td>Based on the Incident Management Bureau’s Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 11 of 36 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>A. Duty To Report:</td>
<td>Individual #24&lt;br&gt;• Incident date 2/8/2012. Allegation was Abuse. Incident report was received 2/27/2012. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</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.</td>
<td>Individual #26&lt;br&gt;• Incident date 4/29/2012. Allegation was Neglect. Incident report was received 5/11/2012. Failure to Report. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</td>
<td></td>
</tr>
<tr>
<td>(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; or 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.</td>
<td>Individual #28&lt;br&gt;• Incident date 5/17/2012. Allegation was Neglect. Incident report was received 5/18/2012. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</td>
<td></td>
</tr>
<tr>
<td>(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 6/7/2012. Allegation was Neglect. Incident report was received 6/8/2012. Late Reporting. IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</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</td>
<td>Individual #29&lt;br&gt;• Incident date 9/12/2011. Allegation was Neglect. Incident report was received</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incident date</th>
<th>Allegation</th>
<th>Incident report was received</th>
<th>Late Reporting</th>
<th>IMB Late &amp; Failure Report indicated incident of Neglect was “Confirmed.”</th>
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</thead>
<tbody>
<tr>
<td>12/12/2011</td>
<td>Neglect</td>
<td>12/13/2011</td>
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<tr>
<td>1/12/2012</td>
<td>Neglect</td>
<td>4/25/2012</td>
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<td>6/4/2012</td>
<td>Neglect</td>
<td>6/6/2012</td>
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<td>1/31/2012</td>
<td>Exploitation</td>
<td>2/10/2012</td>
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<td>10/1/2011</td>
<td>Abuse/Neglect</td>
<td>4/20/2012</td>
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Available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.
<table>
<thead>
<tr>
<th>Incident</th>
<th>Date</th>
<th>Allegation</th>
<th>Report Date</th>
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<tr>
<td>#33</td>
<td>4/26/2012</td>
<td>Neglect Law Enforcement Involvement</td>
<td>6/6/2012</td>
<td>&quot;Confirmed.&quot;</td>
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<tr>
<td>#34</td>
<td>1/9/2012</td>
<td>Emergency Services</td>
<td>1/17/2012</td>
<td>&quot;Confirmed.&quot;</td>
</tr>
<tr>
<td>#35</td>
<td>4/30/2012</td>
<td>Neglect Law Enforcement Involvement</td>
<td>6/6/2012</td>
<td>&quot;Confirmed.&quot;</td>
</tr>
<tr>
<td>#36</td>
<td>6/3/2012</td>
<td>Neglect</td>
<td>6/5/2012</td>
<td>&quot;Confirmed.&quot;</td>
</tr>
</tbody>
</table>
### Standard Level Deficiency

Based on record review, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 4 of 37 Individuals.

During the on-site survey 10/22 – 26, 2012, Surveyors found evidence of 5 internal agency incident reports, which had not been reported to DHI and/or APS/CYFD, as required by regulation.

The following internal incidents were reported as a result of the on-site survey:

<table>
<thead>
<tr>
<th>Individual #</th>
<th>Incident date</th>
<th>Time</th>
<th>Type of incident</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>10/8/2012</td>
<td></td>
<td>Exploitation</td>
<td>Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 12/17/2012 by DHI/QMB.</td>
</tr>
<tr>
<td>20</td>
<td>6/5/2012</td>
<td>1 PM</td>
<td>Use of Law Enforcement</td>
<td>Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 12/17/2012 by DHI/QMB.</td>
</tr>
<tr>
<td></td>
<td>4/25/2012</td>
<td>1 PM</td>
<td>Neglect &amp; Exploitation</td>
<td>Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 12/17/2012 by DHI/QMB.</td>
</tr>
</tbody>
</table>

**Provider:**

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

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

---


Survey Report #: Q.13.2.DDW.1686880.2/3/5.001.RTN.1.042

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communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division’s website: http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.

(2) Division Incident Report Form and Notification by Community Based Service Providers: The community based service provider shall report incidents utilizing the division’s incident report form consistent with the requirements of the division’s incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division’s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.

<table>
<thead>
<tr>
<th>Individual #27</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incident date 1/30/2012 (7:30 AM). Type of incident identified was use of Law Enforcement. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 12/17/2012 by DHI/QMB.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #37</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incident date 10/8/2012 (3:30 PM). Type of incident identified was Abuse. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 12/17/2012 by DHI/QMB.</td>
</tr>
<tr>
<td>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
</tr>
<tr>
<td>A. General: All licensed health care facilities</td>
</tr>
<tr>
<td>and community based service providers shall</td>
</tr>
<tr>
<td>establish and maintain an incident management</td>
</tr>
<tr>
<td>system, which emphasizes the principles of prevention</td>
</tr>
<tr>
<td>and staff involvement. The licensed health care</td>
</tr>
<tr>
<td>facility or community based service provider shall</td>
</tr>
<tr>
<td>ensure that the incident management system policies and</td>
</tr>
<tr>
<td>procedures requires all employees to be competently trained</td>
</tr>
<tr>
<td>to respond to, report, and document incidents in a</td>
</tr>
<tr>
<td>timely and accurate manner.</td>
</tr>
<tr>
<td>E. Consumer and Guardian Orientation Packet: Consumers,</td>
</tr>
<tr>
<td>family members and legal guardians shall be made aware of</td>
</tr>
<tr>
<td>and have available immediate accessibility to the licensed</td>
</tr>
<tr>
<td>health care facility and community based service provider</td>
</tr>
<tr>
<td>incident reporting processes. The licensed health care</td>
</tr>
<tr>
<td>facility and community based service provider shall</td>
</tr>
<tr>
<td>provide consumers, family members or legal guardians an</td>
</tr>
<tr>
<td>orientation packet to include incident management system</td>
</tr>
<tr>
<td>policies and procedural information concerning the</td>
</tr>
<tr>
<td>reporting of abuse, neglect or misappropriation. The</td>
</tr>
<tr>
<td>licensed health care facility and community based service</td>
</tr>
<tr>
<td>provider shall include a signed statement indicating the</td>
</tr>
<tr>
<td>date, time, and place they received their orientation</td>
</tr>
<tr>
<td>packet to be contained in the consumer’s file. The</td>
</tr>
<tr>
<td>appropriate consumer, family member or legal guardian</td>
</tr>
<tr>
<td>shall sign this at the time of orientation.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Survey Report #: Q.13.2.DDW.1686880.2/3/5.001.RTN.1.042
<table>
<thead>
<tr>
<th>Tag # 1A33 Board of Pharmacy - Med Storage</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</td>
<td>Based on observation, the Agency failed to ensure proper storage of medication for 1 of 25 individuals. Observation included: Individual #9 ProAir Inhaler expired 5/2012. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>E. Medication Storage:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Drugs to be taken by mouth will be separate from all other dosage forms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. A locked compartment will be available in the refrigerator for those items labeled “Keep in Refrigerator.” The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Separate compartments are required for each resident’s medication.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. References</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>A. Adequate drug references shall be available for facility staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Controlled Substances (Perpetual Count Requirement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>b. time administered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. name of patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. practitioner’s name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. signature of person administering or assisting with the administration the dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. balance of controlled substance remaining</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 6L06 Family Living Requirements</td>
<td>Standard Level Deficiency</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver</td>
<td>Based on record review, the Agency failed to complete all DDSD requirements for approval of each direct support provider for 2 of 16 individuals.</td>
<td></td>
</tr>
<tr>
<td>Service Standards effective 4/1/2007</td>
<td>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Support to Individuals in Family Living:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Family Living Services Provider Agency shall provide and document:</td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>(a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and</td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>B. Home Studies. 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>

**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: →

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Survey Report #: Q.13.2.DDW.1686880.2/3/5.001.RTN.1.042
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.
**Tag # 6L13 Community Living Healthcare Reqts.**

**Standard Level Deficiency**

Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 9 of 25 individuals receiving Community Living Services.

Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:

- **Dental Exam**
  - Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 1/6/2012. Follow up exam was to be completed in 6 months. No evidence of follow up exam results was found.
  - Individual #13 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
  - Individual #20 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.

- **Vision Exam**
  - Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 8/17/2011. Follow-up was to be completed in 12 months. No evidence of follow-up found.

- **Auditory Exam**
  - Individual #4 - As indicated by collateral documentation reviewed, exam was

**Provider:**

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

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

---

**Tag # 6L13 Community Living Healthcare Reqts.**


**CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING**

**G. Health Care Requirements for Community Living Services.**

(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual’s health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.

(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual’s HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.

(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:

(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E:
<table>
<thead>
<tr>
<th>Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>(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.</td>
</tr>
<tr>
<td>4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</td>
</tr>
<tr>
<td>5) That the physical property and grounds are free of hazards to the individual's health and safety.</td>
</tr>
<tr>
<td>6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</td>
</tr>
<tr>
<td>(a) The individual has a primary licensed physician;</td>
</tr>
<tr>
<td>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</td>
</tr>
<tr>
<td>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</td>
</tr>
<tr>
<td>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</td>
</tr>
<tr>
<td>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</td>
</tr>
</tbody>
</table>

| completed on 9/15/2010. Follow-up was to be completed in 24 months. No evidence of follow-up found. |

- **Orthopedic Exam**
  - Individual #25 - As indicated by collateral documentation reviewed, the exam was ordered for knee pain on 6/14/2012. No evidence of exam results were found.

- **Pap Smear Exam**
  - Individual #25 - As indicated by collateral documentation reviewed, the exam was ordered by Primary Care Physician on 5/2/2011 & 6/14/2012. No evidence of exams results were found.

- **Bone Density Exam**
  - Individual #24 - As indicated by collateral documentation reviewed, the exam was ordered on 6/15/2012. No evidence of exam results was found.

- **Review of Psychotropic Medication**
  - Individual #16 - As indicated by collateral documentation review #16 is to have a medication review every 6 months. No evidence was found for the following time frame to indicate they were completed 1/2012 – 6/2012.

- **Neurological Exam**
  - Individual #22 - As indicated by collateral documentation reviewed, exam was completed on 3/27/2012. At that time a referral for a brain MRI was made. No evidence of MRI found.

- **Podiatry Exam**
  - Individual #22 - As indicated by collateral
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.

documentation reviewed, exam was completed on 7/27/2012. Follow-up was to be completed in 2 months. No evidence of follow-up found.
### Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)

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

**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**

**L. Residence Requirements for Family Living Services and Supported Living Services**

1. Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:

   - **(a)** Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;
   - **(b)** General-purpose first aid kit;
   - **(c)** When applicable due to an individual’s health status, a blood borne pathogens kit;
   - **(d)** Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;
   - **(e)** Accessible telephone numbers of poison control centers located within the line of sight of the telephone;
   - **(f)** Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;
   - **(g)** Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP;
   - **(h)** Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy.

Based on observation, the Agency failed to ensure that each individual’s residence met all requirements within the standard for 11 of 25 Supported Living & Family Living residences.

Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:

**Supported Living Requirements:**

- Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#20)
- Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#7, 27)
- Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP (#20)
- Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#20)

**Family Living Requirements:**

- Accessible written procedures for emergency evacuation

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evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

- Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#3, 11, 12, 14, 15, 22, 23)

- Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 12, 14)

Note: Individuals #7 & 27 share a residence.
### Standard of Care

**Deficiencies**

**Agency Plan of Correction, On-going QA/QI & Responsible Party**

<table>
<thead>
<tr>
<th>Date Due</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Tag # 5I36  Community Access Reimbursement</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 2 of 4 individuals. Individual #9 July 2012  • The Agency billed 200 units of Community Access (H2021 U1) from 7/22/2012 through 8/4/2012. Documentation received accounted for 48 units. August 2012  • The Agency billed 140 units of Community Access (H2021 U1) from 8/5/2012 through 8/18/2012. Documentation did not contain the required elements on 8/5, 11 &amp; 12, 2012. Documentation received accounted for 76 units. One or more of the following elements was not met:  ➢ The signature or authenticated name of staff providing the service. September 2012  • The Agency billed 140 units of Community Access (H2021 U1) from 9/16/2012 through 9/29/2012. Documentation did not contain the required elements on 9/16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29. Documentation received accounted for 0 units. One of the following elements was not met:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

**Provider:**

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

**Provider:**

MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary


Survey Report #: Q.13.2.DDW.1686880.2/3/5.001.RTN.1.042

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to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


**CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS**

**G. Reimbursement**

(1) **Billable Unit:** A billable unit is defined as one-quarter hour of service.

(2) **Billable Activities:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions:

- (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual’s ISP, Action Plan;
- (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and
- (c) Non face-to-face hours do not exceed 10% of the monthly billable hours.

(3) **Non-Billable Activities:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:

- (a) Time and expense for training service personnel;

  ➢ No documentation found.
(b) Supervision of agency staff;
(c) Service documentation and billing activities; or
(d) Time the individual spends in segregated facility-based settings activities.
**Tag # 5I44  Adult Habilitation Reimbursement**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A. General:</strong> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</td>
<td></td>
</tr>
<tr>
<td><strong>B. Billable Units:</strong> 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:</td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</td>
<td></td>
</tr>
<tr>
<td>(2) A description of what occurred during the encounter or service interval; and</td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
<td></td>
</tr>
</tbody>
</table>

**MAD-MR: 03-59 Eff 1/1/2004**

**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 6 of 12 individuals.</td>
<td></td>
</tr>
<tr>
<td><strong>Individual #1</strong> August 2012</td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 235 units of Adult Habilitation (T2021 U1, U4) from 8/19/2012 through 9/1/2012. Documentation did not contain the required elements on 8/20, 21, 22, 28, 29, 30. Documentation received accounted for 72 units. One of the following elements was not met:</td>
<td></td>
</tr>
<tr>
<td>➢ No documentation found.</td>
<td></td>
</tr>
<tr>
<td><strong>September 2012</strong></td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 200 units of Adult Habilitation (T2021 U1, U4) from 9/16/2012 through 9/30/2012. Documentation did not contain the required elements on 9/18, 26, 27. Documentation received accounted for 192 units. One of the following elements was not met:</td>
<td></td>
</tr>
<tr>
<td>➢ No documentation found.</td>
<td></td>
</tr>
<tr>
<td><strong>Individual #7</strong> July 2012</td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 40 units of Adult Habilitation (T2021 U2) from 7/8/2012 through 7/21/2012. Documentation received accounted for 29 units.</td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 72 units of Adult Habilitation (T2021 U2) from 7/22/2012 through 8/4/2012. Documentation received accounted for 12 units.</td>
<td></td>
</tr>
</tbody>
</table>

CHAPTER 5 XVI. REIMBURSEMENT

A. Billable Unit. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual’s level of care.

B. Billable Activities
(1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and (b) Non face-to-face hours do not exceed 5% of the monthly billable hours.

(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours.

Individual #16
July 2012
- The Agency billed 240 units of Adult Habilitation (T2021 U1) from 7/22/2012 through 8/4/2012. Documentation received accounted for 216 units.

September 2012
- The Agency billed 276 units of Adult Habilitation (T2021 U1) from 9/2/2012 through 9/15/2012. Documentation received accounted for 272 units.

Individual #19
August 2012
- The Agency billed 176 units of Adult Habilitation (T2021 U1 U4) from 8/5/2012 through 8/18/2012. Documentation received accounted for 174 units.

Individual #24
July 2012
- The Agency billed 120 units of Adult Habilitation (T2021 U1) from 7/22/2012 through 8/4/2012. Documentation received accounted for 114 units.

August 2012
- The Agency billed 200 units of Adult Habilitation (T2021 U1) from 8/19/2012 through 9/1/2012. Documentation received accounted for 136 units.

September 2012
- The Agency billed 60 units of Adult Habilitation (T2021 U1) from 9/16/2012 through 9/29/2012. Documentation received accounted for 36 units.

Individual # 25
July 2012
• The Agency billed 72 units of Adult Habilitation (T2021 U1) from 7/8/2012 through 7/21/2012. Documentation received accounted for 48 units.

August 2012
• The Agency billed 48 units of Adult Habilitation (T2021 U1) from 8/5/2012 through 8/18/2012. Documentation did not contain the required elements on 8/5 - 18. Documentation received accounted for 24 units.
<table>
<thead>
<tr>
<th>Tag # 6L26</th>
<th>Supported Living Reimbursement</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 failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 9 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</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>(2) A description of what occurred during the encounter or service interval; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.2.DDW.1686880.2/3/5.001.RTN.1.042

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

A. Reimbursement for Supported Living Services

(1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.

(2) Billable Activities
(a) Direct care provided to an individual in the residence any portion of the day.
(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.
(c) Any activities in which direct support staff provides in accordance with the Scope of Services.

(3) Non-Billable Activities
(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.
(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.
(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.
<table>
<thead>
<tr>
<th>Tag # 6L27</th>
<th>Family Living Reimbursement</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A. General:</strong> All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Billable Units:</strong> 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:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) A description of what occurred during the encounter or service interval; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to

| **Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 3 of 16 individuals.** |
| **Individual #15** September 2012 |
| • The Agency billed 13 units of Family Living (T2033) from 8/24/2012 through 9/5/2012. Documentation did not contain the required elements on 9/4. Documentation received accounted for 12 units. One or more of the following elements was not met: |
| ➢ Date, start and end time of each service encounter or other billable service interval. |

| **Individual #16** July 2012 |
| • The Agency billed 21 units of Family Living (T2033) from 7/19/2012 through 8/8/2012. Documentation did not contain the required elements on 8/7 and 8. Documentation received accounted for 19 units. One or more of the following elements was not met: |
| ➢ Date, start and end time of each service encounter or other billable service interval. |

| **August 2012** |
| • The Agency billed 7 units of Family Living (T2033) from 8/9/2012 through 8/15/2012. Documentation did not contain the required elements on 8/9, 10, 11, 12, 14. Documentation received accounted for 2 units. One or more of the following elements was not met: |
| ➢ Date, start and end time of each service encounter or other billable service interval. |

**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.13.2.DDW.1686880.2/3/5.001.RTN.1.042

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

B. Reimbursement for Family Living Services

<table>
<thead>
<tr>
<th>Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) Billable Activities shall include:</td>
</tr>
<tr>
<td>(a) Direct support provided to an individual in the residence any portion of the day;</td>
</tr>
<tr>
<td>(b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and</td>
</tr>
<tr>
<td>(c) Any other activities provided in accordance with the Scope of Services.</td>
</tr>
<tr>
<td>(3) Non-Billable Activities shall include:</td>
</tr>
<tr>
<td>(a) The Family Living Services Provider Agency may not bill the for room and board;</td>
</tr>
<tr>
<td>(b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and</td>
</tr>
<tr>
<td>(c) Family Living services may not be billed for the same time period as Respite.</td>
</tr>
<tr>
<td>(d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>September 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>● The Agency billed 14 units of Family Living (T2033) from 8/23/2012 through 9/5/2012. Documentation did not contain the required elements on 8/28. Documentation received accounted for 13 units. One or more of the following elements was not met:</td>
</tr>
<tr>
<td>➢ Date, start and end time of each service encounter or other billable service interval.</td>
</tr>
<tr>
<td>● The Agency billed 7 units of Family Living (T2033) from 9/6/2012 through 9/12/2012. Documentation did not contain the required elements on 9/10 &amp; 11. Documentation received accounted for 5 units. One or more of the following elements was not met:</td>
</tr>
<tr>
<td>➢ Date, start and end time of each service encounter or other billable service interval.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #23</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2012</td>
</tr>
<tr>
<td>● The Agency billed 5 units of Family Living (T2033) from 9/1/2012 through 9/5/2012. Documentation did not contain the required elements on 9/1/2012. Documentation received accounted for 4 units. One of the following elements was not met:</td>
</tr>
<tr>
<td>➢ The signature or authenticated name of staff providing the service.</td>
</tr>
</tbody>
</table>

*Note: Daily note on 9/1/2012 stated, “I was gone.”*
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - Chapter 6 - COMMUNITY LIVING SERVICES

III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.

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

SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.
Dear Ms. Dahl-Nunn,

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 previously cited survey Deficiencies have been corrected, except for Tag 6L13, Individual #22, for a Neurological exam. According to the original Report of Findings, the Individual required an MRI which was recommended during the Neurological exam on 3/27/2012. No verification was provided verifying this exam was completed. You do not need to submit further documentation for this citation, but please ensure the exam has been completed and/or scheduled and a copy of the results have been placed in the individual's file.

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 of 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 for the health, safety and personal growth of the people you serve.
Sincerely,

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

Q.13.4.DDW.1686880.2/3/5.001.RTN.09.123