



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: September 1, 2011

To: Diane Nunn, Executive Director
Provider: The New Beginnings, LLC
Address: 8908 Washington St. NE
State/Zip: Albuquerque, New Mexico 87113

E-mail Address: dnunn@tnbabq.com

Region: Metro & Southwest
Routine Survey: November 15 – 19, 2010
Verification Survey: July 5 – 8, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living, Independent Living & Family Living) & Community Inclusion (Adult Habilitation & Community Access)

Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Crystal Lopez-Beck, Division of Health Improvement/Quality Management Bureau

Dear Ms. Nunn;

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI/DDSD regarding the Routine Survey on November 15 – 19, 2010.

These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

Please call the Plan of Correction Coordinator at 505-222-8647, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Tony Fragua, BFA

Tony Fragua, BFA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau



Division of Health Improvement • Quality Management Bureau
5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – The New Beginnings LLC – Metro & Southwest Region – July 5 – 8, 2011

Survey Report #: Q12.01.11686880.METRO&SW.001.VS.01

Survey Process Employed:

Entrance Conference Date: July 5, 2011

Present: **The New Beginnings, LLC**
Jackie DeVizio, Human Resource Manager

DOH/DHI/QMB
Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Crystal Lopez-Beck, Healthcare Surveyor

Exit Conference Date: July 6, 2011

Present: **The New Beginnings, LLC**
Diana Nunn, Executive Director
Ken Sangha, Operations Manager
Jackie DeVizio, Human Resource Manager

DOH/DHI/QMB
Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Crystal Lopez-Beck, Healthcare Surveyor

Total Homes Visited Number: 4 (5 Other Individuals who required home visits were not seen as they were available during the on-site verification survey).

❖ Family Homes Visited Number: 4

Administrative Locations Visited Number: 1

Total Sample Size Number: 25
3 - Jackson Class Members
22 - Non-Jackson Class Members
5 - Supported Living
17 - Family Living
3 - Independent Living
11 - Adult Habilitation
3 - Community Access

Records Reviewed (Persons Served) Number: 25

Direct Service Personnel Record Review Number: 303

Service Coordinator Record Review Number: 6

Administrative Files Reviewed

- 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
- 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

QMB Scope and Severity Matrix

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

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

Scope and Severity Definitions:

- **Isolated:**
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.

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

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

QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. 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 Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of ‘Non-Compliance’ may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of ‘Substandard Compliance’ will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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 that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding. 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.
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.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed 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 QMB compliance determination 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.

QMB has 30 business days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. The Provider will be notified in writing of the ruling; no face to face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is 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: The New Beginnings, LLC – Metro & Southwest Regions
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey
Date of Routine Survey: November 15 – 19, 2010
Date of Verification Survey: July 5 – 8, 2011

Standard of Care	November 15 - 19, 2010 Deficiencies	July 5 - 8, 2011 Verification Survey - New and Repeat Deficiencies
Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: D	Scope and Severity Rating: D
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 7 of 260 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #202 – Date of hire 3/10/2010. Completed 3/19/2010. • #247 – Date of hire 3/19/2010. Completed 3/19/2010. • #256 – Date of hire 3/08/2010. Completed 3/19/2010. • #285 – Date of hire 10/01/2007. Completed 10/25/2007. • #289 – Date of hire 9/06/2007. Completed 10/25/2007. • #290 – Date of hire 7/16/2007. Completed 7/31/2007. 	<p>New and Repeat findings:</p> <p>Based on record review, the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 2 of 309 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #337 – Date of hire 5/26/2011. Completed 7/06/2011. • #338 – Date of hire 5/26/2011. Completed 7/06/2011.

care or services from a provider.

D. **Documentation of inquiry to registry.** The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

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

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

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

Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All

- #293 – Date of hire 9/06/2007. Completed 1/07/2008.

Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(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.</p> <p>(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.</p> <p>B. Notification: (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division's incident report form. The incident report form and instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.</p>	<p>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 9 of 35 individuals.</p> <p>Individual #1</p> <ul style="list-style-type: none"> Incident date 4/13/2010. Allegation was Abuse. Incident report was received 5/11/2010. Late Reporting. IMB Late & Failure Report indicated incident of Abuse was "Confirmed." <p>Individual #28</p> <ul style="list-style-type: none"> Incident date 12/28/2009. Allegation was Exploitation. Incident report was received 1/04/2010. Late Reporting. IMB Late & Failure Report indicated incident of Exploitation was "Confirmed." <p>Individual #29</p> <ul style="list-style-type: none"> Incident date 1/29/2010. Allegation was Exploitation. Incident report was received 1/29/2010. Late Reporting. IMB Late & Failure Report indicated incident of Exploitation was "Confirmed." <p>Individual #30</p> <ul style="list-style-type: none"> Incident date 6/15/2010. Allegation was Neglect. Incident report was received 6/16/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #31</p> <ul style="list-style-type: none"> Incident date 6/22/2010. Allegation was Neglect. Incident report was received 6/22/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #32</p> <ul style="list-style-type: none"> Incident date 8/10/2010. Allegation was 	<p>New and Repeat Finding:</p> <p>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 1 of 33 individuals.</p> <p>Individual #32</p> <ul style="list-style-type: none"> Incident date 1/03/2011. Allegation was Abuse, Neglect & Exploitation. Incident report was received 1/05/2011. Failure to Report. IMB Late & Failure Report indicated incident of Abuse & Exploitation was "Confirmed." Incident date 2/08/2011. Allegation was Exploitation. Incident report was received 2/09/2011. Failure to Report. IMB Late & Failure Report indicated incident of Neglect & Exploitation was "Confirmed."

	<p>Exploitation. Incident report was received 8/11/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."</p> <p>Individual #33</p> <ul style="list-style-type: none"> • Incident date 8/17/2010. Allegation was Neglect. Incident report was received 8/17/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #34</p> <ul style="list-style-type: none"> • Incident date 8/07/2010. Allegation was Neglect. Incident report was received 8/17/2010. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #35</p> <ul style="list-style-type: none"> • Incident date 8/09/2010. Allegation was Abuse. Incident report was received 8/19/2010. Late Reporting. IMB Late & Failure Report indicated incident of Abuse was "Confirmed." 	
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Tag # 1A32 (CoP) ISP Implementation	Scope and Severity Rating: D	Scope and Severity Rating: D
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>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.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>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 3 of 27 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #17</p> <ul style="list-style-type: none"> • No Outcomes for Family Living Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #1</p> <ul style="list-style-type: none"> • None found for 9/2010. <p>Individual #15</p> <ul style="list-style-type: none"> • No Outcomes for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver." 	<p>Repeat Finding:</p> <p>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 1 of 25 individuals.</p> <p>Per Individual's ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #15</p> <ul style="list-style-type: none"> • No Outcomes for Adult Habilitation Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: E	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first.</p> <p>(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.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</p> <p>b) That each individual with a score of 4, 5, or 6</p>	<p>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 5 of 27 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Vision Exam <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #23 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #24 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #27 - As indicated by the Annual physical PCP recommends auditory exam every two years, the Annual was completed on 12/2009. No evidence of an auditory exam was found. • Blood Levels <ul style="list-style-type: none"> ◦ Individual #10 - As indicated per Neurological evaluation recommends review for Valporic acid levels, lab work was ordered on 12/08/2009. Follow-up was to be completed every 6 months, last Valporic acid level checked 3/2010. No evidence of follow-up found. • Review of Psychotropic Medication <ul style="list-style-type: none"> • Individual #17 - According to Pharmacologic Management visit Individual #17 is to have a medication review in 6-months. No evidence 	<p>Repeat Finding:</p> <p>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 1 of 25 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Vision Exam <ul style="list-style-type: none"> ◦ Individual #17 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.

<p>on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(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.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p>	<p>was found for the following time frame to indicate they were completed (3/31/2010 – 9/2010).</p>	
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Tag # 6L25.1 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D	Scope and Severity Rating: D
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals.</p> <p>(3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP.</p> <p>(4) Living and Dining Areas shall</p> <p>(a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests;</p> <p>(b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and</p> <p>(c) Provide environmental accommodations based on the unique needs of the individual.</p> <p>(5) Kitchen area shall:</p> <p>(a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day;</p> <p>(b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and</p> <p>(c) Water temperature is required to be maintained at a safe level to both prevent</p>	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 18 Family Living residences.</p> <p>Family Living Requirements:</p> <p>During on-site visit (11/15/2010), surveyors observed the following:</p> <p>Surveyors on routine survey made a house visit to Individual #11 on November 15, 2010 at 3:30pm. During on-site visit, surveyors made these observations: The home in general was unkempt with spider webs throughout the home including bathroom, kitchen and individuals bedroom.</p> <p>Kitchen table had layer of film which was sticky to the touch. Stove had layer of grease and spider webs on side of stove to the wall.</p> <p>Bathroom had a black ring of soap scum, spider webs between shower wall and shower head and handle.</p> <p>Individuals bedroom was dusty and had spider webs throughout room</p> <p>An addition was added to home but remains unfinished, building supplies were observed in hallway. Electrical components were hanging from walls, although no exposed wires were observed.</p> <p>Residential concerns were brought to the attention of Executive Director of Agency.</p>	<p>Repeat Finding:</p> <p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 4 Family Living residences.</p> <p>Family Living Requirements:</p> <p>During on-site visit (7/5/2011), surveyors observed the following:</p> <p>Surveyors visited the home of Individual #11 on July 5, 2011 at 3:45pm. Observations were made to assess Agency's corrections to routine survey deficiencies noted in the home during the 11/2010 survey. During verification on-site visit, surveyors made the following observations: The home was still in disarray and in an unkempt condition. The condition of the bathroom, kitchen and individual's bedroom had not improved. Surveyors noted same environmental hazards as reported in Routine Survey dated November 15 – 19, 2010.</p> <p>As per the Plan Of Correction submitted to DHI/QMB for the November 2010 survey the Agency stated the following:</p> <ul style="list-style-type: none"> • "The Family Living Provider has been informed regarding the issues identified. The home will be cleaned and the construction materials will be moved to better promote the health and safety of the individual receiving services. A monthly check will be completed by the service coordinator. Responsible Person: Diane Dahl Nunn, Executive Director" <p>The Agency failed to implement the plan of correction as agreed to.</p>

injury and ensure comfort.

(6) Bedroom area shall:

- (a) At a maximum of two (2) individuals share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;
- (b) All bedrooms shall have doors, which may be closed for privacy
- (c) Physical arrangement of bedrooms compatible with the physical needs of the individual; and
- (d) Allow individuals the right to decorate his or her bedroom in a style of his or her choice consistent with a safe and sanitary living conditions.

(7) Bathroom area shall provide:

- (a) For Supported Living, a minimum of one toilet and lavatory facility for every two (2) individuals with Developmental Disabilities living in the home;
- (b) Reasonable modifications or accommodations, based on the physical needs of the individual (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.):
 - (i) Toilets, tubs, showers used by the individual(s) provide for privacy; designed or adapted for the safe provision of personal care; and
 - (ii) Water temperature maintained at a safe level to prevent injury and ensure comfort.

Standard of Care	November 15 - 19, 2010 Scope and Severity Ratings	July 5 - 8, 2011 Verification Survey – Plan of Correction Process Verification Results
Tag # 1A08 Agency Case File	Scope and Severity Rating: A	Completed
Tag # 1A09 Medication Delivery (MAR) - Routine Medication	Scope and Severity Rating: E	Completed
Tag # 1A09.1 Medication Delivery - PRN Medication	Scope and Severity Rating: E	Completed
Tag # 1A09.2 Medication Delivery - PRN Nurse Approval	Scope and Severity Rating: D	Completed
Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: D	Completed
Tag # 1A20 DSP Training Documents	Scope and Severity Rating: D	Completed
Tag # 1A22 Staff Competence	Scope and Severity Rating: E	Completed
Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: D	Completed
Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E	Completed
Tag # 1A29 Complaints / Grievances – Acknowledgement	Scope and Severity Rating: A	Completed
Tag # 1A31 (CoP) Client Rights/Human Rights	Scope and Severity Rating: D	Completed
Tag # 1A33 Board of Pharmacy - Med Storage	Scope and Severity Rating: A	Completed
Tag # 1A33.1 Board of Pharmacy – Lic	Scope and Severity Rating: A	Completed
Tag # 1A37 Individual Specific Training	Scope and Severity Rating: D	Completed

Tag # 5I11 Reporting Requirements (Community Inclusion Quarterly Reports)	Scope and Severity Rating: A	Completed
Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	Completed
Tag # 5I44 AH Reimbursement	Scope and Severity Rating: C	Completed
Tag # 6L06 (CoP) - FL Requirements	Scope and Severity Rating: D	Completed
Tag # 6L14 Residential Case File	Scope and Severity Rating: E	Completed
Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: E	Completed
Tag # 6L27 FL Reimbursement	Scope and Severity Rating: B	Completed

SUSANA MARTINEZ, GOVERNOR



BRAD McGRATH, INTERIM SECRETARY

Date: November 20, 2012

To: Ms. Diane Nunn, Executive Director

Provider: The New Beginnings, LLC
Address: 8908 Washington Street NE
State/Zip: Albuquerque, New Mexico 87113

Region: Metro

Survey Date: January 4 - 6, 2012

Program Surveyed: Developmental Disabilities Waiver

Services Surveyed: Community Living (Supported Living)

Survey Type: Focused

Dear Ms. Nunn:

On January 4-6, 2012, the Quality Management Bureau completed a Focused Survey of your agency at the request of the Internal Review Committee (IRC). The Department is pleased to inform you that due to your cooperation with the Plan of Correction Process and all IRC directives, you have completed all the requirements per the Internal Review Committee (IRC).

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Crystal Lopez-Beck". The signature is written in a cursive, flowing style.

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

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