Dear Ms. Diane 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:

**Non-Compliance with Conditions of Participation**
The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A32 & LS14/6L14 Individual Service Plan Implementation
- Tag # LS13/6L13 Community Living and Healthcare Requirements
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A09 Medication Delivery Routine Medication Administration

This determination is based on non-compliance with three or more CMS waiver assurances at the Condition of Participation level as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings 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 Anthony Fragua at 505-231-7436 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.
Sincerely,

Meg Pell, BA

Meg Pell, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: December 8, 2014

Present:

**The New Beginnings, LLC**
Diane Dahl-Nunn, Executive Director
Kelly Krinke, Service Coordinator Supervisor

**DOH/DHI/QMB**
Meg Pell, BA, Team Lead/Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor
Jenny Bartos, BA, Healthcare Surveyor
Amanda Castaneda, MPA, Healthcare Surveyor
Florence Mulheron, BA, Healthcare Surveyor

Exit Conference Date: December 12, 2014

Present:

**The New Beginnings, LLC**
Diane Dahl-Nunn, Executive Director
Kelly Krinke, Service Coordinator Supervisor
Desiree Martinez, RN
Matt Crawforth, Service Coordinator
Dan Davis, Service Coordinator
Terri Corrao, Service Coordinator
Molli Bass, Service Coordinator
Jackie DeVizio, Human Resources

**DOH/DHI/QMB**
Meg Pell, BA, Team Lead/Healthcare Surveyor
Nicole Brown, MBA, Healthcare Surveyor
Corrina B. Strain, RN-BSN, Healthcare Surveyor
Jenny Bartos, BA, Healthcare Surveyor

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 36

- 6 - Jackson Class Members
- 30 - Non-Jackson Class Members
- 12 - Supported Living
- 20 - Family Living
- 5 - Adult Habilitation
- 14 - Customized Community Supports
- 4 - Customized In-Home Supports

Total Homes Visited
Number: 24

- Supported Living Homes Visited
Number: 7

*Note: The following Individuals share a SL residence:*
- #2, 25, 35
- #17, 21
- #33, 36
Family Living Homes Visited  Number: 17

Persons Served Records Reviewed  Number: 36

Persons Served Interviewed  Number: 26

Persons Served Observed  Number: 10 (2 individuals were beginning hospice and requested privacy, 1 individual's Family living provider had the flu, 1 Individual declined the interview and left the home, 1 individual was in the shower and 5 individuals were not available )

Direct Support Personnel Interviewed  Number: 46

Direct Support Personnel Records Reviewed  Number: 245

Substitute Care/Respite Personnel Records Reviewed  Number: 48

Service Coordinator Records Reviewed  Number: 7

Administrative Processes and Records Reviewed:

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

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-231-7436 or email at Anthony.Fragua@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

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

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
   a. Electronically at Anthony.Fragua@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.

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

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

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

e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

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

**POC Document Submission Requirements**

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

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

2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).

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

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

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

6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:

   - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
   - Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.
Attachment B

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

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

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

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

The Determination of Compliance for each service type is based on a provider’s compliance with CoPs in three (3) Service Domains.
   Case Management Services:
     • Level of Care
     • Plan of Care
     • Qualified Providers

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

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

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

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

**QMB Determinations of Compliance**

**Compliance with Conditions of Participation**

Survey Report #: Q.15.2/DDW.11686880.3&5.RTN.01.14.079
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.
Introduction:
Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated “Document Request,” or “Administrative Needs,” etc. forms. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status. If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| **Service Domain: Service Plans: ISP Implementation** – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan. | Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 7 of 36 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
  - ISP Signature Page (#9, 11, 21)  
  - Individual Specific Training Section of ISP (#21)  
  - Positive Behavioral Support Plan (#8)  
  - Documentation of Guardianship/Power of Attorney (#7, 21)  
  - Annual Physical (#13)  
  - Dental Exam  
    - Individual #26 - As indicated by collateral documentation reviewed, exam was | 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: → |          |
comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:

1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.

Chapter 7 (CIHS) 3. Agency Requirements:
E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 11 (FL) 3. Agency Requirements:
D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 12 (SL) 3. Agency Requirements:
D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 13 (IMLS) 2. Service Requirements:
C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)
• Emergency contact information;
• Personal identification;
• ISP budget forms and budget prior authorization;
• ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan

completed on 9/9/2014. Follow up for wisdom tooth extraction was to be completed. No evidence of follow-up found. Per agency nurse follow up was still to be scheduled with the dentist.

• Vision Exam
  ° Individual #13 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
(PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI);
• Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay;
• Copy of Guardianship or Power of Attorney documents as applicable;
• Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;
• Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;
• Progress notes written by DSP and nurses;
• Signed secondary freedom of choice form;
• Transition Plan as applicable for change of provider in past twelve (12) months.

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director’s Release: Consumer Record Requirements eff. 11/1/2012
III. Requirement Amendments(s) or Clarifications:
A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director’s release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

**CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:

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

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

3. Progress notes and other service delivery documentation;

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

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

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

7. Case records belong to the individual receiving services and copies shall be provided to the individual upon request.
(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:
(a) Complete file for the past 12 months;
(b) ISP and quarterly reports from the current and prior ISP year;
(c) Intake information from original admission to services; and
(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

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

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1</th>
<th>Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</strong></td>
<td><strong>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 1 of 36 Individuals.</strong></td>
<td><strong>Provider:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 5 (CIES) 3. Agency Requirements:</strong> <strong>6. Reimbursement A. 1.</strong> <strong>...</strong></td>
<td><strong>Review of the Agency individual case files revealed the following items were not found:</strong></td>
<td><strong>State your Plan of Correction for the deficiencies cited in this tag here: →</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</strong></td>
<td><strong>Supported Living Progress Notes/Daily Contact Logs</strong></td>
<td><strong>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 6 (CCS) 3. Agency Requirements:</strong> <strong>4. Reimbursement A. Record Requirements 1.</strong> <strong>...</strong></td>
<td><strong>• Individual #34 - None found for 8/30/2014.</strong></td>
<td><strong>→</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</strong></td>
<td><strong>Chapter 7 (CIHS) 3. Agency Requirements:</strong> <strong>4. Reimbursement A. 1.</strong> <strong>...</strong></td>
<td><strong>→</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</strong></td>
<td><strong>Chapter 11 (FL) 3. Agency Requirements:</strong> <strong>4. Reimbursement A. 1.</strong> <strong>...</strong></td>
<td><strong>→</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</strong></td>
<td><strong>Chapter 12 (SL) 3. Agency Requirements:</strong> <strong>2. Reimbursement A. 1.</strong> <strong>...</strong></td>
<td><strong>Provider:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provider Agencies must maintain all records necessary to fully disclose the service, quality...The documentation of the billable time spent with an individual shall be kept on the written or electronic record...</strong></td>
<td><strong>...</strong></td>
<td><strong>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</strong></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 13 (IMLS) 3. Agency Requirements:
4. Reimbursement A. 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…

Chapter 15 (ANS) 4. Reimbursement A. 1. …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record…


CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: 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:

(3) Progress notes and other service delivery documentation;
<table>
<thead>
<tr>
<th>Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAC 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.</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</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>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 11 of 36 individuals.</td>
<td></td>
</tr>
<tr>
<td>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Administrative Files Reviewed:</td>
<td>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Individual #17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• According to the Live Outcome; Action Step for: “Gather and separate her dirty clothes” is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 - 10, 11 – 15, 17 - 31, 9/2014 and 10/1 – 3, 5 - 10, 19 – 24, 26 – 31, 2014.</td>
<td>• According to the Live Outcome; Action Step for: “Will put her laundry in the washer and set controls” is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 - 10, 11 – 15,</td>
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<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</tbody>
</table>


Survey Report #: Q.15.2.DDW.11686880.3&5.RTN.01.14.079
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]

- According to the Live Outcome; Action Step for: “Will transfer her clothes to the dryer and set controls” is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 - 10, 11 – 15, 17 - 31, 9/2014 and 10/1 – 3, 5 - 10, 19 – 24, 26 – 31, 2014.

- According to the Live Outcome; Action Step for: “Will fold or hang up all of her laundry” is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 - 10, 11 – 15, 17 - 31, 9/2014 and 10/1 – 3, 5 - 10, 19 – 24, 26 – 31, 2014.

- According to the Live Outcome; Action Step for: “Will put up all of her laundry where it belongs” is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 - 10, 11 – 15, 17 - 31, 9/2014 and 10/1 – 3, 5 - 10, 19 – 24, 26 – 31, 2014.

<table>
<thead>
<tr>
<th>Individual #20</th>
</tr>
</thead>
<tbody>
<tr>
<td>- According to the Live Outcome; Action Step for: “Will use adaptive equipment to puree her food” is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 – 22/2014.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #34</th>
</tr>
</thead>
<tbody>
<tr>
<td>- According to the Live Outcome; Action Step for: “Will attend an art class” is to be</td>
</tr>
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</table>
completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2014 - 9/2014.

- According to the Have Fun/Develop Relationships Outcome; Action Step for: “Will pick his outing” is to be completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 6/2014 - 9/2014.

**Individual #36**
- Review of Agency’s documented Outcomes and Action Steps do not match the current (6/12/2014 - 6/11/2015) ISP Outcomes and Action Steps for Live Outcome. No documentation was found regarding implementation of ISP outcomes for 8/2014.

**Agency’s Outcomes/Action Steps are as follows:**
- “Will engage in volunteer work in volunteer work in an animal shelter/facility”

**Annual ISP (6/12/2014 - 6/11/2015) Outcomes/Action Steps are as follows:**
- “Will research tablet choices and prices”

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

**Individual #8**
- According to the Live Outcome; Action Step for: “Will complete one household chore” is to be completed 1 time per week, evidence found indicated it was not being completed...
at the required frequency as indicated in the ISP for 9/19 – 30, 2014.

- According to the Fun Outcome; Action Step for: “Will go on new activities in the community and participate in the activity” for 2 activities per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/6 - 30/2014 and 10/7 – 31/2014.

Individual #10
- According to the Live Outcome; Action Step for: “Will choose location/document the duration of the walks” is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2014 - 10/2014.

Individual #37
- According to the Live Outcome; Action Step for: “With assistance …will plan/make choices of family activities” is to be completed 2 times per month, evidence found indicated that it was not being completed at the required frequency for 10/2014 and 11/2014.

Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #7
- None found regarding: Work/learn Outcome: “Will learn one sign word a month over the next year” for Action Step: “Will learn 18 sign words within the next year” for 9/2014.
• According to the Work/Learn Outcome: “Will learn one sign word a month over the next year” for Action Step: “Will learn 18 sign words within the next year” is to be completed daily, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2014 and 10/2014.

Individual #8
• According to the Work/Learn Outcome; Action Step for: “Will choose an activity in the community and participate in the activity” for 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/1 – 14, 21 – 31; 9/1 – 5, 7 – 19, 23 – 30; 10/1 – 7, 15 – 31, 2014.

Individual #9
• According to the Work/Learn Outcome; Action Step for: “Will research places to listen to music” for 1 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2014, 9/2014 and 10/2014.

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

Individual #17
• None found regarding: Work/learn, Outcome/Action Step: “Will choose a hobby store to go to” 1 - 2 times per month for 8/2014 - 10/2014.
<table>
<thead>
<tr>
<th>Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #3</td>
</tr>
<tr>
<td>• According to the Live Outcome; Action Step for &quot;Will engage and complete a household chore 3 times per week,&quot; evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2014 - 10/2014.</td>
</tr>
<tr>
<td>• According to the Health Outcome; Action Step for &quot;Will exercise 1 hour per week,&quot; evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2014, 5/2014, 9/2014 and 10/2014.</td>
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<tr>
<th>Residential Files Reviewed:</th>
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<tr>
<th>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #6</td>
</tr>
<tr>
<td>• “Will exercise” is to be completed 3 times per week. Action Step was not being completed at the required frequency for 12/1 – 7, 2014.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Individual #17</th>
</tr>
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<tbody>
<tr>
<td>• None found regarding: Fun Outcome/Action Step: &quot;Will choose a date to entertain a friend or family member&quot; weekly for 12/1 – 8, 2014.</td>
</tr>
<tr>
<td>• None found regarding: Fun Outcome/Action Step: &quot;Will make an invitation and take it to the post office&quot; weekly for 12/1 – 8, 2014.</td>
</tr>
</tbody>
</table>
None found regarding: Fun Outcome/Action Step: "Will create a menu" weekly for 12/1 – 8, 2014.

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

Individual #9
- None found regarding: Fun Outcome/Action Step: "Will attend the business of his choice to see his friend that he has made" 1 time per week for 12/1 – 9, 2014.

- None found regarding: Fun Outcome/Action Step: "Will utilize his VOCA to ask a question to his friend, i.e. lunch, coffee etc." 1 time per week for 12/1 – 9, 2014.
### Tag # LS14 / 6L14
#### Residential Case File

|-----------------------------------------------|

<table>
<thead>
<tr>
<th><strong>CHAPTER 11 (FL) 3. Agency Requirements</strong></th>
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</table>

#### C. Residence Case File: The Agency must maintain in the individual’s home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.

<table>
<thead>
<tr>
<th><strong>CHAPTER 12 (SL) 3. Agency Requirements</strong></th>
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</thead>
</table>

#### C. Residence Case File: The Agency must maintain in the individual’s home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.

<table>
<thead>
<tr>
<th><strong>CHAPTER 13 (IMLS) 2. Service Requirements B.1. Documents To Be Maintained In The Home:</strong></th>
</tr>
</thead>
</table>

- a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access;
- b. Personal identification;
- c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans ) as applicable;
- d. Dated and signed consent to release information forms as applicable;
- e. Current orders from health care practitioners;
- f. Documentation and maintenance of accurate medical history in Therap website;
- g. Medication Administration Records for the current month;
- h. Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided;
- i. Progress notes written by DSP and nurses;
- j. Documentation and data collection related to ISP implementation;
- k. Medicaid card;

#### Standard Level Deficiency

- Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 23 of 32 Individuals receiving Family Living Services and/or Supported Living Services.

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

- **Current Emergency and Personal Identification Information**
  - None Found (#24)
- Did not contain a Current address (#7)
- Did not contain phone number for the individual’s physician (#21)
- Did not contain Health Plan Information (#6, 8, 17, 19, 33, 34, 36, 39)
- Advanced Directives (#30) *(Per individual’s ISP Advanced Directives are required and should be located in their book at home.)*
- Annual ISP (#27, 30)
- Individual Specific Training Section of ISP *(formerly Addendum B) (#21, 27)*

#### Teaching and Support Strategies

- Individual #12 - *TSS not found for the following Action Steps:*
  - Live Outcome Statement
    - “Enter the correct time on the microwave.”

---

**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: →
I. Salud membership card or Medicare card as applicable; and
m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable.

DEVELOPMENTAL DISABILITIES SUPPORTS
DIVISION (DDSD): Director’s Release: Consumer
Record Requirements eff. 11/1/2012

III. Requirement Amendments(s) or Clarifications:
A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director’s release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS
A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual’s home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual’s home, the complete and current confidential case file for each individual shall be maintained at the agency’s administrative site. Each file shall include the following:
(1) Complete and current ISP and all supplemental plans specific to the individual;
(2) Complete and current Health Assessment Tool;
(3) Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician’s name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;

<table>
<thead>
<tr>
<th>Individual #17 - TSS not found for the following Action Steps:</th>
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<tbody>
<tr>
<td>Fun Outcome Statement</td>
</tr>
<tr>
<td>“…will choose a date to entertain a friend.”</td>
</tr>
<tr>
<td>“…will make an invitation and take it to the post office.”</td>
</tr>
<tr>
<td>“…will create a menu.”</td>
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</table>

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<thead>
<tr>
<th>Individual #21 - TSS not found for the following Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Outcome Statement # 1</td>
</tr>
<tr>
<td>“…and staff will identify what needs to be cleaned in her room.”</td>
</tr>
<tr>
<td>“…will clean her room.”</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Individual #33 - TSS not found for the following Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fun Outcome Statement</td>
</tr>
<tr>
<td>“Will plan his meals.”</td>
</tr>
<tr>
<td>“Will grocery shop.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #36 - TSS not found for the following Action Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Outcome Statement</td>
</tr>
<tr>
<td>“Research tablet choices and prices.”</td>
</tr>
<tr>
<td>“Will learn the new features of the tablet.”</td>
</tr>
<tr>
<td>Requirement</td>
</tr>
<tr>
<td>-------------</td>
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</tbody>
</table>
| (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); | ° Fun Outcome Statement
  ➢ “Research and plan a trip using the Rail Runner as transportation.”
  ➢ “Will research a day trip to a local ghost town.” |
| (5) Data collected to document ISP Action Plan implementation | • Positive Behavioral Plan (#7, 14, 23) |
| (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; | • Positive Behavioral Crisis Plan (#7, 8, 17, 23, 28) |
| (7) Physician’s or qualified health care providers written orders; | • Speech Therapy Plan (#2, 37) |
| (8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s); | • Occupational Therapy Plan (#31) |
| (9) Medication Administration Record (MAR) for the past three (3) months which includes: | • Physical Therapy Plan (#37) |
| (a) The name of the individual; | • Healthcare Passport (#6, 12, 17, 21, 24, 36, 37) |
| (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; | • Special Health Care Needs |
| (c) Diagnosis for which the medication is prescribed; | ° Nutritional Plan (#7, 33) |
| (d) Dosage, frequency and method/route of delivery; | ° Comprehensive Aspiration Risk Management Plan:
  ➢ Not Current (#2, 37) |
| (e) Times and dates of delivery; | • Health Care Plans |
| (f) Initials of person administering or assisting with medication; and | ° Aspiration (#35) |
| (g) An explanation of any medication irregularity, allergic reaction or adverse effect. | ° Basal Metabolic Index (#11, 14, 35) |
| (h) For PRN medication an explanation for the use of the PRN must include: | ° Bowel and Bladder (#35) |
| (i) Observable signs/symptoms or circumstances in which the medication is to be used, and | ° Constipation (#6, 23, 35) |
| (ii) Documentation of the effectiveness/result of the PRN delivered. | ° Diabetes (#6) |
| (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 | ° Hypertension (#6) |
| | ° Falls (#25) |
| | ° Oral Hygiene (#23) |
| | ° Pain (#35) |
| | ° Respiratory (#35) |
| | ° Seizures (#35) |
an updated copy must be placed in the agency file on a weekly basis.

(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

- Skin Integrity (#35)
- Tube Feeding (#35)

### Medical Emergency Response Plans
- Aspiration (#8, 35)
- Diabetes (#6)
- Falls (#25)
- Pain (#35)
- Respiratory (#35)
- Seizures (#17, 35)
- Tube Feeding (#35)

### Progress Notes/Daily Contacts Logs:
- Individual #4 - None found for 12/1 – 8, 2014.
Service Domain: Qualified Providers – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>

Tag # 1A11.1 Transportation Training

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

II. POLICY STATEMENTS:
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:
1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)

NMAC 7.9.2 F. TRANSPORTATION:
(1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training

Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 16 of 245 Direct Support Personnel.

No documented evidence was found of the following required training:
- Transportation (DSP #266, 293, 319, 325, 336, 347, 349, 350, 351, 358, 359, 433, 438, 439)

When DSP were asked if they had received transportation training including training on the agency’s policies and procedures following was reported:
- DSP #231 stated, “No, but have been driving my whole life.”
- DSP #349 stated, “No, I have been trained by… (DSP stated another agency).”
- DSP #371 stated, “No training here.”

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.15.2.DDW.11686880.3&5.RTN.01.14.079
Page 31 of 146
program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.

(2) Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:

(a) A state approved training program in passenger assistance and

(b) A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.

(c) A valid New Mexico drivers license for the type of vehicle being operated consistent with State of New Mexico requirements.

(3) Each regulated facility and agency shall establish and enforce written policies (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.

(4) Each regulated facility and agency shall establish and enforce written policies (including
training and procedures for employees who operate motor vehicles to transport clients.


CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: Training
Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 136 of 245 Direct Support Personnel.</td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
<td></td>
</tr>
<tr>
<td>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
<td>- Pre- Service (DSP #295, 299, 308, 315, 343, 344, 346, 351, 358, 359, 386, 416, 418, 419, 420, 426, 439)</td>
<td></td>
</tr>
<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
<td>- Foundation for Health and Wellness (DSP #216, 228, 236, 249, 295, 297, 305, 308, 315, 317, 320, 343, 348, 351, 358, 359, 418, 420, 422, 425, 439)</td>
<td></td>
</tr>
<tr>
<td>D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</td>
<td>- Person-Centered Planning (1-Day) (DSP #236, 253, 339, 340, 348, 350, 375, 387, 418, 423, 426, 434)</td>
<td></td>
</tr>
<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
<td>- First Aid (DSP #204, 210, 221, 234, 238, 243, 257, 270, 271, 272, 277, 290, 302, 305, 316, 320, 325, 328, 332, 336, 354, 357, 365, 392, 393, 406, 418, 432, 435, 436, 439, 441)</td>
<td></td>
</tr>
<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
<td>- CPR (DSP #204, 210, 234, 238, 243, 246, 257, 270, 271, 272, 277, 290, 302, 305, 316, 320, 325, 328, 332, 336, 345, 354, 355, 392, 393, 406, 418, 432, 436, 441)</td>
<td></td>
</tr>
<tr>
<td>G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.</td>
<td>- Assisting With Medication Delivery (DSP #200, 201, 205, 208, 209, 210, 213, 214, 216, 219, 221, 222, 223, 224, 226, 232, 234, 238, 240, 241, 242, 243, 246, 251, 262, 263, 265, 272, 273, 278, 279, 280, 285, 286, 287, 289,</td>
<td></td>
</tr>
<tr>
<td>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
<td></td>
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</tr>
<tr>
<td>I. Staff providing direct services shall complete safety training within the first thirty (30) days of</td>
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</table>


Survey Report #: Q.15.2.DDW.11686880.3&5.RTN.01.14.079
employment and before working alone with an individual receiving service.


CHAPTER 5 (CIES) 3. Agency Requirements G.
Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 6 (CCS) 3. Agency Requirements F.
Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

CHAPTER 7 (CIHS) 3. Agency Requirements C.
Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 11 (FL) 3. Agency Requirements B.
Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training


- Rights and Advocacy (DSP #236, 267, 327, 363, 414, 418, 422, 430, 435)

- Positive Behavior Supports Strategies (DSP #233, 236, 267, 298, 301, 327, 339, 363, 380, 389, 403, 414, 418, 421, 422, 426, 429, 435)

- Teaching and Support Strategies (DSP #236, 267, 301, 302, 327, 389, 403, 414, 418, 423, 435)
Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Agency Personnel Competency</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 9 of 46 Direct Support Personnel. When DSP were asked if they received training on the Individual’s Individual Service Plan and what the plan covered, the following was reported:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>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) for each individual served.</td>
<td>• DSP #340 stated “No training for…yet.” (Individual #27) 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>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</td>
<td>• DSP #340 stated, “I haven’t been trained on this book.” According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #27) When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</td>
<td>• DSP #434 stated, “She did when I first got her but she no longer has those issues.” According to the Individual Specific Training Section of the ISP the individual has Positive Behavioral Crisis Plan. (Individual #7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documenting DDSD Training Requirements Policy.

- DSP #340 stated, “I haven’t been trained on this book.” According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #27)

When DSP were asked if the Individual had a Comprehensive Aspiration Risk Management Plan and if so, what the plan(s) covered, the following was reported:

- DSP #371 stated, “No.” As indicated by the Individual Specific Training Section of the ISP the Individual requires a Comprehensive Aspiration Risk Management Plan (Individual #37)

When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:

- DSP #423 stated, “No, I don’t think so.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Seizures (Individual #4)

- DSP #336 stated, “Diabetes Type II, blood level, constipation, hypertension.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Falls (Individual #6)

- DSP #231 stated, “Seizures.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Aspiration. (Individual #8)
### Documentation for DDSD Training Requirements.

**B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.**

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### CHAPTER 12 (SL) 3. Agency Requirements

**B. Living Supports - Supported Living Services Provider Agency Staffing Requirements: 3. Training:**

**A. All Living Supports - Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.**

---

<table>
<thead>
<tr>
<th>DSP</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>#259</td>
<td>Stated “falls.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Body Mass Index (Individual #14)</td>
</tr>
<tr>
<td>#340</td>
<td>Reported that she hadn’t been trained. As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for respiratory. (Individual #27)</td>
</tr>
<tr>
<td>#452</td>
<td>Stated, “I haven’t seen them.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for seizure and respiratory. (Individual #31)</td>
</tr>
<tr>
<td>#371</td>
<td>Stated, “… kind of went over some of that.” DSP was not able to name any of the Individual’s Health Care Plans. As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for aspiration, constipation and skin and wound (Individual #37)</td>
</tr>
</tbody>
</table>

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

- DSP #336 stated, “Diabetes.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for falls. (Individual #6)
- DSP #340 reported that she hadn’t been trained. As indicated by the Electronic...
B. Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual’s preferences with regard to privacy, communication style, and routines.

Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARM, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications. 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;

Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Respiratory. (Individual #27)

- DSP #452 stated, “I haven’t seen them.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for seizure and respirator. (Individual #31)

- DSP #371 stated, “I don’t have none of that.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for aspiration and constipation. (Individual #37)

When DSP were asked if the Individual had a Seizure Disorder, the following was reported:

- DSP #452 stated, “No, not that I’m aware of.” As indicated by the Individual’s Electronic Health Assessment Tool the individual has been diagnosed with epilepsy. (Individual #37)

When DSP were asked if the Individual had bowel or bladder issues, the following was reported:

- DSP #371 stated, “No” As indicated by the Individual’s Electronic Health Assessment Tool the individual is diagnosed with chronic constipation, hemorrhoids, irritable bowel syndrome and bowel and bladder incontinence. (Individual #37)

When DSP were asked, what are the steps did they need to take before assisting an
<table>
<thead>
<tr>
<th>individual with PRN medication, the following was reported:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• DSP #231 stated, “…approved by Doc.” According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #8)</td>
</tr>
</tbody>
</table>

When DSP were asked if they knew what the individual’s Diagnosis were, the following was reported:

| • DSP #452 reported that the individual is diagnosed with sight loss, fetal alcohol syndrome, and learning disability. According to the individual’s Electronic Comprehensive Health Assessment Tool, the individual is also diagnosed with bipolar disorder, epilepsy and mild intellectual disability. Staff did not discuss the listed diagnoses. (Individual #31) |
| • DSP #371 stated, “No.” According to the individual’s Electronic Comprehensive Health Assessment Tool, the individual is diagnosed with seasonal allergies, cerebral palsy, chronic constipation, depression with anxiety, hemorrhoids, hepatitis c, hypertension, irritable bowel syndrome, mild intellectual disabilities, osteoporosis, and bowel and bladder incontinence. Staff did not discuss the listed diagnoses. (Individual #37) |

When DSP were asked if they received training on the Individual’s Meal Time Plan/Comprehensive Aspiration Risk
Management Plan and what the plan covered, the following was reported:

- DSP #229 stated, “No, I know what to do but I never knew what a CARMP was.” As indicated by the Individual Specific Training section of the ISP the individual has a Meal Time Plan/Comprehensive Aspiration Risk Management Plan. (Individual #20)

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 #231 stated, “No, no known allergies”. As indicated by Electronic Comprehensive Health Assessment Tool the individual is allergic to minocycline, cephalaxin, Sudafed and morphine. (Individual #8)

- DSP #340 stated, “No, no known allergies to any foods or medications.” As indicated by Electronic Comprehensive Health Assessment Tool the individual is allergic to Chantix and Codeine. (Individual #27)

- DSP #452 stated, “I don’t know.” As indicated by the individual’s Electronic Health Assessment Tool the individual is allergic to Tegretol and Wellbutrin. (Individual #31)
<table>
<thead>
<tr>
<th>Tag # 1A25CALL</th>
<th>Criminal Caregiver History Screening</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.9.8</td>
<td>CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:</td>
<td>Based on record review, the Agency did not maintain documentation indicating no &quot;disqualifying convictions&quot; or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 9 of 300 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>F. Timely Submission:</td>
<td>Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.</td>
<td>NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>A. Prohibition on Employment:</td>
<td>A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.</td>
<td>(1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime.</td>
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<tr>
<td>(2) An applicant’s, caregiver’s or hospital caregiver’s failure to respond within the required</td>
<td>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>Direct Support Personnel (DSP):</td>
<td></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>• #352 – Date of hire 12/13/2011.</td>
<td>• #250 – Date of hire 12/23/2011.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #252 – Date of hire 7/19/2007.</td>
<td>• #271 – Date of hire 4/16/2012.</td>
<td></td>
<td></td>
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<tr>
<td>• #317 – Date of hire 9/18/2014.</td>
<td>• #320 – Date of hire 1/30/2014.</td>
<td></td>
<td></td>
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<tr>
<td>• #321 – Date of hire 4/17/2007.</td>
<td>• #413 – Date of hire 11/18/2014.</td>
<td></td>
<td></td>
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<tr>
<td>• #321 – Date of hire 4/17/2007.</td>
<td>• #317 – Date of hire 9/18/2014.</td>
<td></td>
<td></td>
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<tr>
<td>• #320 – Date of hire 1/30/2014.</td>
<td>• #321 – Date of hire 4/17/2007.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #413 – Date of hire 11/18/2014.</td>
<td>• #321 – Date of hire 4/17/2007.</td>
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</table>


Survey Report #: Q.15.2.DDW.11686880.3&5.RTN.01.14.079
timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the applicant’s, caregiver’s or hospital caregiver’s temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9.

(3) The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9.

B. Employment Pending Reconsideration Determination: At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.
<table>
<thead>
<tr>
<th>DISQUALIFYING CONVICTIONS</th>
<th></th>
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<tbody>
<tr>
<td>The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:</td>
<td></td>
</tr>
<tr>
<td><strong>A.</strong> homicide;</td>
<td></td>
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<tr>
<td><strong>B.</strong> trafficking, or trafficking in controlled substances;</td>
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</tr>
<tr>
<td><strong>C.</strong> kidnapping, false imprisonment, aggravated assault or aggravated battery;</td>
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<tr>
<td><strong>D.</strong> rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;</td>
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</tr>
<tr>
<td><strong>E.</strong> crimes involving adult abuse, neglect or financial exploitation;</td>
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<tr>
<td><strong>F.</strong> crimes involving child abuse or neglect;</td>
<td></td>
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<tr>
<td><strong>G.</strong> crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or</td>
<td></td>
</tr>
<tr>
<td><strong>H.</strong> an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.</td>
<td></td>
</tr>
<tr>
<td>Tag # 1A26</td>
<td>Consolidated On-line Registry Employee Abuse Registry</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED:** Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.  
A. **Provider requirement to inquire of registry.** A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.  
B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.  
D. **Documentation of inquiry to registry.** The provider shall maintain documentation in the employee’s personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that |
| Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 300 Agency Personnel.  
The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:  
**Direct Support Personnel (DSP):**  
- #353 – Date of hire 10/25/2012, completed 10/2/2014. | **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: →  
}
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.
### NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS

**A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures require all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.

**B. Training curriculum:** Prior to an employee or volunteer’s initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider’s facility. Training shall be conducted in a language that is understood by the employee or volunteer.

**C. Incident management system training curriculum requirements:**

<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review and interview, the Agency did not ensure Incident Management Training for 22 of 252 Agency Personnel.</td>
<td></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service Coordination Personnel (SC):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (SC #445, 446)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers’ Property, the following was reported:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• DSP #423 stated, “I can’t remember. APS, Call police.” Staff was not able to identify the State Agency as DHI/IMB.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• DSP #364 stated, “Here to the agency.” Staff was not able to identify the State Agency as DHI/IMB.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

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


Survey Report #: Q.15.2/DDW.11686850.35/RTN.01.14.079

Page 49 of 146
(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:
(a) an overview of the potential risk of abuse, neglect, or exploitation;
(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;
(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;
(d) specific instructions on how to respond to abuse, neglect, or exploitation;
(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.
(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.
(3) All new employees and volunteers shall receive training prior to providing services to consumers.

D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be
made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.

**Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007**

**II. POLICY STATEMENTS:**

A. Individuals shall receive services from competent and qualified staff.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
Tag # 1A36  
Service Coordination Requirements

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 2 of 7 Service Coordinators.</td>
</tr>
</tbody>
</table>

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

- Pre-Service Part One (SC #450)
- Person Centered Planning (2-Day) (SC #450)
- Promoting Effective Teamwork (SC #449, 450)
- Participatory Communication and Choice Making (SC #449)
- Positive Behavior Supports Strategies (SC #449, 450)
- Advocacy Strategies (SC #450)
- ISP Critique (SC #450)
- Sexuality for People with Developmental Disabilities (SC #449, 450)
- Level 1 Health (SC #449, 450)

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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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:

K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training:

1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency.
2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency.
3. Level I – must be completed within one (1) year of assignment to his/her position with the agency.

NMAC 7.26.5.7 “service coordinator”: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency.

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

(i) the designated service coordinator shall
have the skills necessary to carry out the
duties and responsibilities of the case
manager as defined in these regulations;
(ii) the designated service coordinator shall
have the time and interest to fulfill the
functions of the case manager as defined in
these regulations;
(iii) the designated service coordinator shall
be familiar with and understand community
service delivery and supports;
(iv) the designated service coordinator shall
know the individual or be willing to become
familiar and develop a relationship with the
individual being served;
## Tag # 1A37
Individual Specific Training

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as &quot;Addendum B&quot;) training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.</td>
</tr>
<tr>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 23 of 252 Agency Personnel. Review of personnel records found no evidence of the following:</td>
</tr>
</tbody>
</table>

**Direct Support Personnel (DSP):**

**Service Coordination Personnel (SC):**
- Individual Specific Training (SC #446) |

**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.15.2.DDW.11686880.3&5.RTN.01.14.079
status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and
Documentation for DDSD Training Requirements.
B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 12 (SL) 3. Agency Requirements
B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.
B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
Service Domain: Health and Welfare – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>1A03 CQI System</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</td>
<td>Based on record review the Agency did not implement their Continuous Quality Management System as required by standard. Review of the Agency’s CQI Plan revealed the following: • The Agency’s Continuous Quality Improvement Plan provided during the on-site survey (December 8 - 12, 2014) was not dated. No evidence was found indicating when the document had been created or updated. Also, based on evidence found during the on-site survey and reflected in this report of findings the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>

CHAPTER 5 (CIES) 3. Agency Requirements: J. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of ISPs: extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:

a. Analysis of General Events Reports data in Therap;
b. Compliance with Caregivers Criminal History Screening requirements;
c. Compliance with Employee Abuse Registry requirements;
d. Compliance with DDSD training requirements;
e. Patterns of reportable incidents;
f. Results of improvement actions taken in previous quarters;
g. Sufficiency of staff coverage;
h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes;
i. Results of General Events Reporting data analysis;
j. Action taken regarding individual grievances;
k. Presence and completeness of required documentation;
l. A description of how data collected as part of the agency’s QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; and
m. Significant program changes.

CHAPTER 6 (CCS) 3. Agency Requirements: I. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the
development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.

1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. **Implementing a QI Committee:** The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following:
   a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
   b. Analysis of General Events Reports data;
   c. Compliance with Caregivers Criminal History Screening requirements;
   d. Compliance with Employee Abuse Registry requirements;
   e. Compliance with DDSD training requirements;
   f. Patterns of reportable incidents; and
   g. Results of improvement actions taken in previous quarters.
3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
   a. Sufficiency of staff coverage;
   b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes;
   c. Results of General Events Reporting data analysis;
   d. Action taken regarding individual grievances;
   e. Presence and completeness of required documentation;
   f. A description of how data collected as part of the agency’s QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
   g. Significant program changes.

CHAPTER 7 (CIHS) 3. Agency Requirements: G. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the
source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of ISPs: The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;

   b. Analysis of General Events Reports data;

   c. Compliance with Caregivers Criminal History Screening requirements;

   d. Compliance with Employee Abuse Registry requirements;

   e. Compliance with DDSD training requirements;

   f. Patterns of reportable incidents; and

   g. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available
for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:

a. Sufficiency of staff coverage;

b. Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes;

c. Results of General Events Reporting data analysis;

d. Action taken regarding individual grievances;

e. Presence and completeness of required documentation;

f. A description of how data collected as part of the agency’s QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and

g. Significant program changes.

CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program: Family Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan
describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. **Implementing a QA/QI Committee**: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:
   a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
   b. Analysis of General Events Reports data;
   c. Compliance with Caregivers Criminal History Screening requirements;
   d. Compliance with Employee Abuse Registry requirements;
   e. Compliance with DDSD training requirements;
   f. Patterns in reportable incidents; and
   g. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
   a. Sufficiency of staff coverage;
b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;
c. Results of General Events Reporting data analysis, Trends in category II significant events;
d. Patterns in medication errors;
e. Action taken regarding individual grievances;
f. Presence and completeness of required documentation;
g. A description of how data collected as part of the agency's QI plan was used;
h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
i. Significant program changes.

CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and
methods to evaluate whether implementation of improvements are working.

2. **Implementing a QA/QI Committee**: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:
   a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;
   b. Analysis of General Events Reports data;
   c. Compliance with Caregivers Criminal History Screening requirements;
   d. Compliance with Employee Abuse Registry requirements;
   e. Compliance with DDSD training requirements;
   f. Patterns in reportable incidents; and
   g. Results of improvement actions taken in previous quarters.

2. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH, and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
   a. Sufficiency of staff coverage;
   b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;
   c. Results of General Events Reporting data analysis, Trends in Category II significant events;
   d. Patterns in medication errors;
e. Action taken regarding individual grievances;
f. Presence and completeness of required documentation;
g. A description of how data collected as part of the agency’s QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
h. Significant program changes.

CHAPTER 13 (IMLS) 3. Service Requirements:
F. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.

1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living
providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:

a. Implementation of the ISPs, including the extent to which services are delivered in accordance with the ISPs and associated support plans and/or WDSI including the type, scope, amount, duration, and frequency specified in the ISPs as well as effectiveness of such implementation as indicated by achievement of outcomes;
b. Trends in General Events as defined by DDSD;
c. Compliance with Caregivers Criminal History Screening Requirements;
d. Compliance with DDSD training requirements;
e. Trends in reportable incidents; and
f. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes:

a. Sufficiency of staff coverage;
b. Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes;
c. Trends in reportable incidents;
d. Trends in medication errors;
e. Action taken regarding individual grievances;
f. Presence and completeness of required documentation;
g. How data collected as part of the agency’s QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
h. Significant program changes.

CHAPTER 14 (ANS) 3. Service Requirements:
N. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.

1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:
   a. Trends in General Events as defined by DDSD;
   b. Compliance with Caregivers Criminal History Screening Requirements;
   c. Compliance with DDSD training requirements;
   d. Trends in reportable incidents; and
e. Results of improvement actions taken in previous quarters.

3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes:
   a. Sufficiency of staff coverage;
   b. Trends in reportable incidents;
   c. Trends in medication errors;
   d. Action taken regarding individual grievances;
   e. Presence and completeness of required documentation;
   f. How data collected as part of the agency’s QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
   g. Significant program changes

NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:
F. Quality assurance/quality improvement program for community-based service providers:
The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division’s investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide
the following internal monitoring and facilitating quality improvement program:

1. Community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;

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

3. Community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.
<table>
<thead>
<tr>
<th>Tag # 1A06 Policy and Procedure Requirements</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>
| STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT ARTICLE 14. STANDARDS FOR SERVICES AND LICENSING | Based on interview, the Agency did not ensure Agency Personnel were aware of the Agency’s On-Call Policy and Procedures for 2 of 46 Agency Personnel. When DSP were asked if the agency had an on-call procedure, the following was reported:  
  - DSP #223 stated that they would “call the service coordinator”, however, DSP was unable to provide the after-hours telephone number by looking through their phone (Individual #13)  
  - DSP #351 stated, “(They) haven’t gone over it with me.” (Individual #30) | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |

ARTICLE 39. POLICIES AND REGULATIONS
Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD…

PROVIDER APPLICATION NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION COMMUNITY PROGRAMS BUREAU Effective 10/1/2012 Revised 3/2014 Section V DDW Program Descriptions 2. DD Waiver Policy and Procedures (coversheet and page numbers required)  
d. To ensure the health and safety of individuals receiving services, as required in the DDSD Service Standards, please provide your agency’s  
i. Emergency and on-call procedures;

3. Additional Program Descriptions for DD Waiver Adult Nursing Services (coversheet and page numbers required)
| a. Describe your agency’s arrangements for on-call nursing coverage to comply with PRN aspects of the DDSD Medication Assessment and Delivery Policy and Procedure as well as response to individuals changing condition/unanticipated health related events; |

**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.

**B. Provider Agency Policy and Procedure Requirements:** All Provider Agencies, in addition to requirements under each specific service standard shall at a minimum develop, implement and maintain, at the designated Provider Agency main office, documentation of policies and procedures for the following:

1. Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency;
2. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and
3. Agency protocols for disaster planning and emergency preparedness.
**Tag # 1A09**  
**Medication Delivery**  
**Routine Medication Administration**

| Condition of Participation Level Deficiency | **Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: →  
**Provider:**  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
|------------------------------------------|-------------------------------------------------|
| **NMAC 16.19.11.8 MINIMUM STANDARDS:**  
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:  
(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.**  
This documentation shall include:  
(i) Name of resident;  
(ii) Date given;  
(iii) Drug product name;  
(iv) Dosage and form;  
(v) Strength of drug;  
(vi) Route of administration;  
(vii) How often medication is to be taken;  
(viii) Time taken and staff initials;  
(ix) Dates when the medication is discontinued or changed;  
(x) The name and initials of all staff administering medications. |  |
| **Model Custodial Procedure Manual**  
**D. Administration of Drugs**  
Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.  
Document the practitioner’s order authorizing the self-administration of medications.  
All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:  
- symptoms that indicate the use of the medication,  
- exact dosage to be used, and |  |
| **After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.**  
Medication Administration Records (MAR) were reviewed for the months of November and December 2014.  
Based on record review 16 of 32 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:  
**Individual #4**  
**November 2014**  
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:  
- Topamax 100 MG (2 times daily) – Blank 11/7 (8:00 PM) |  |
| **Individual #6**  
**December 2014**  
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:  
- Abilify 30 mg (1 time daily)  
- Buproprion HCL XL 300 mg (1 time daily)  
- Loratadine 10 mg (1 time daily)  
- Griseofulvin Ultra 250 mg (1 time daily)  
- Trazadone 100 mg (1 time daily) |  |
the exact amount to be used in a 24 hour period.


CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8. Providing assistance with medication delivery as outlined in the ISP; C. Individual Community Integrated Employment 3. Providing assistance with medication delivery as outlined in the ISP; D. Group Community Integrated Employment 4. Providing assistance with medication delivery as outlined in the ISP; and

B. Community Integrated Employment Agency Staffing Requirements: o. Comply with DDSD Medication Assessment and Delivery Policy and Procedures;

CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. C. Small Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. D. Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy.

CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services: The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): 19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy.

Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Bupropion HCL XL 300 mg (1 time daily)
  - Blank 12/8 (8:00 PM)

Individual #7
During on-site survey Physician Orders were requested. As of 12/12/2014, Physician Orders had not been provided. (Individual #7)

Individual #8
November 2014
As indicated by the Medication Administration Records the individual is to take Depakote 500 mg “1 tab in the AM, 2 tabs in the PM” According to the Physician’s Orders, Depakote 1000 mg is to be taken in the AM and Depakote 500mg is to be taken in the PM. Medication Administration Record and Physician’s Orders do not match.

As indicated by the Medication Administration Records the individual is to take Tegretol 200 mg 3 times daily. According to the Physician’s Orders, Tegretol 200 mg is to be taken 2 times daily and Tegretol 300 mg is to be taken 1 time daily at 3 PM. Medication Administration Record and Physician’s Orders do not match.

Individual #10
November 2014
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:
- Metoprolol 100 mg ½ tablet (1 time daily)
- Montelukast 10 mg (1 time daily)
New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and

I. Healthcare Requirements for Family Living.

3. B. Adult Nursing Services for medication oversight are required for all surrogate Living Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.

6. Support Living- Family Living Provider Agencies must 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 New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.

   a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

   b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

      i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

      • Flovent Inhaler 110 mcg 2 puffs (2 times daily)
      • Vitamin D3 400mg (1 time daily)
      • Baby Aspirin 81 mg (1 time daily)
      • Benadryl 25 mg (3 times daily)
      • Codeine 30 mg (1 time daily)
      • Prilosec 30 mg (1 time daily)
      • Melatonin 3 mg (1 time daily)
      • Gabapentin 300 mg (1 time daily)
      • Mirtazipine 15 mg (1 time daily)
      • Calcium 600 mg (1 time daily)

Individual #11
November 2014
During on-site survey Medication Administration Records were requested for months of November and December 2014. As of 12/12/2014, Medication Administration Records for November had not been provided.

Individual #17
November 2014
As indicated by the Medication Administration Records the individual is to take Diazepam 2mg 2 times daily. According to the Physician’s Orders, Diazepam 5 mg tablet is to be taken 2 times daily Medication Administration Record and Physician’s Orders do not match.
ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;

v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

c. The Family Living Provider Agency must 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; and

d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.

e. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.

As indicated by the Medication Administration Records the individual is to take Olanzapine 20 mg 2 times daily. According to the Physician's Orders, Olanzapine 10 mg ½ tablet is to be taken 3 times daily Medication Administration Record and Physician's Orders do not match.

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Divalproex Sod ER 500 mg (1 time daily every morning)
- Divalproex Sod ER 500 mg (1 time daily every evening)
- Phenytoin Chew 50 mg (1 time daily at bedtime)

December 2014

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Ranitidine 150 mg (1 times daily)
- Preplus CAFE 27 mg-FA 1 mg (1 time daily)
- Phenytoin 75 mg 1 ½ tablets (1 time daily)
- Olanzapine 20 mg (2 time daily)
- Levothyroxine 75 mcg (1 time daily)
- Divalproex Sodium 500 mg (every morning)
- Divalproex Sodium 500 mg (every evening)

Individual #23
November 2014
i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual’s response to medications for purpose of accurately completing required nursing assessments.

ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.

iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided.

**CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication Delivery:** Supported Living Provider Agencies must 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, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations:

<table>
<thead>
<tr>
<th>Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Alprazolam .5 mg (2 times daily)</td>
</tr>
<tr>
<td>• Natural fiber laxative capsule .52 g (2 times daily)</td>
</tr>
</tbody>
</table>

Physician’s Orders indicated the following medication was to be given. The following Medication was not documented on the Medication Administration Records:

- Zolpidem Tartrate 5 mg (1 time daily)

**December 2014**

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Amoxicillin 125 mg (2 times daily)

**Individual #24**

November 2014

As indicated by the Medication Administration Records the individual is to take Sertraline 1.25 ml 1 time daily. According to the Physician’s Orders, Sertraline 25 mg is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match.

**December 2014**

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:

- Sertraline 1.25 mg (1 time daily)

**Individual #27**

November 2014

Medication Administration Records contain the following medications. No Physician’s
b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;

v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

c. The Supported Living Provider Agency must 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; and

d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service

<table>
<thead>
<tr>
<th>Orders were found for the following medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abilify 10 mg (1 time daily)</td>
</tr>
<tr>
<td><strong>Individual #29</strong> November 2014</td>
</tr>
<tr>
<td>As indicated by the Medication Administration Records the individual is to take Risperdal 1 mg 3 times daily. According to the Physician’s Orders, Risperdal 2 mg is to be taken 3 times daily. Medication Administration Record and Physician’s Orders do not match.</td>
</tr>
<tr>
<td>Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
</tr>
<tr>
<td>• Aspirin 81 mg (1 time daily)</td>
</tr>
<tr>
<td><strong>Individual #30</strong> November 2014</td>
</tr>
<tr>
<td>Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:</td>
</tr>
<tr>
<td>• Zyprexa 10 mg (1 time daily)</td>
</tr>
<tr>
<td>• Lovastatin 10 mg (1 time daily)</td>
</tr>
<tr>
<td><strong>Individual #31</strong> November 2014</td>
</tr>
<tr>
<td>As indicated by the Medication Administration Records the individual is to take Seroquel 1000 mg 1 time daily. According to the Physician’s Orders, Seroquel 400 mg is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match.</td>
</tr>
<tr>
<td><strong>Individual #33</strong> November 2014</td>
</tr>
</tbody>
</table>
locations and must include the expected
desired outcomes of administering the
medication, signs, and symptoms of adverse
events and interactions with other
medications.

CHAPTER 13 (IMLS) 2. Service
Requirements. B. There must be compliance
with all policy requirements for Intensive Medical
Living Service Providers, including written policy
and procedures regarding medication delivery
and tracking and reporting of medication errors
consistent with the DDSD Medication Delivery
Policy and Procedures, relevant Board of
Nursing Rules, and Pharmacy Board standards
and regulations.

Developmental Disabilities (DD) Waiver
Service Standards effective 4/1/2007
CHAPTER 1 II.
PROVIDER AGENCY
REQUIREMENTS:
E. Medication Delivery: Provider
Agencies that provide Community Living,
Community Inclusion or Private Duty Nursing
services shall have written policies and
procedures regarding medication(s) delivery
and tracking and reporting of medication errors
in accordance with DDSD Medication
Assessment and Delivery Policy and
Procedures, the Board of Nursing Rules and
Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication
Assessment and Delivery Policy, Medication
Administration Records (MAR) shall be
maintained and include:
(a) The name of the individual, a
transcription of the physician’s written or
licensed health care provider’s
prescription including the brand and
generic name of the medication,

Medication Administration Records contain
the following medications. No Physician’s
Orders were found for the following
medications:
- Fluoxetine HCL 20 mg (1 time daily)
- Hydrocortizone 2.5% cream (2 times daily)
- Patanol 0.1% eye drops (2 times daily)

Physician’s Orders indicated the following
medication were to be given. The following
Medications were not documented on the
Medication Administration Records:
- Paroxetine HCL 40 mg (1 time daily)

Medication Administration Records contained
missing entries. No documentation found
indicating reason for missing entries:
- Risperidone 2 mg (1 times daily) – Blank
11/28 (8:00 AM)

Individual #38
November 2014
As indicated by the Medication Administration
Records the individual is to take Ranitidine 15
mg/5ml 1ml (every 2 hours during the day).
According to the Physician’s Orders,
Ranitidine 15mg/5ml per G-tube at “11:00,
13:00, 17:00 and 21:00.” Medication
Administration Record and Physician’s Orders
do not match.

Individual #39
November 2014
Medication Administration Records contain
the following medications. No Physician’s
Orders were found for the following
medications:
- Fluoxetine HCL 20 mg (1 time daily)
- Hydrocortizone 2.5% cream (2 times daily)
- Patanol 0.1% eye drops (2 times daily)

Medication Administration Records contained
missing entries. No documentation found
indicating reason for missing entries:
- Risperidone 2 mg (1 times daily) – Blank
11/28 (8:00 AM)
diagnosis for which the medication is prescribed;
(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.
(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

- Olive Oil 2 drops to each ear (2 times weekly)
- Calcium Citrate 630 mg (2 times daily)
- Omega 3 300 mg (2 times daily)
- Active Kids Vitamin (2 times daily)
- Ear Wax Drop 1 drop in right ear (2 times per week)
<table>
<thead>
<tr>
<th>Tag # 1A09.1</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Delivery PRN Medication Administration</td>
<td><strong>Standard Level Deficiency</strong>&lt;br&gt;Medication Administration Records (MAR) were reviewed for the months of November and December 2014. Based on record review, 1 of 32 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: <strong>Individual #23</strong>&lt;br&gt;November 2014 Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:&lt;br&gt;- Antacid 500 mg (PRN)&lt;br&gt;- Chloraseptic 1.4% (PRN)&lt;br&gt;- Simethicone 40 MG/.6 ML Suspension (PRN)</td>
</tr>
</tbody>
</table>

**A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:**<br>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.**<br>This documentation shall include:<br>(i) Name of resident;<br>(ii) Date given;<br>(iii) Drug product name;<br>(iv) Dosage and form;<br>(v) Strength of drug;<br>(vi) Route of administration;<br>(vii) How often medication is to be taken;<br>(viii) Time taken and staff initials;<br>(ix) Dates when the medication is discontinued or changed;<br>(x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual**<br>*D. Administration of Drugs*<br>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.<br>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:<br>- symptoms that indicate the use of the medication,<br>- exact dosage to be used, and |
- the exact amount to be used in a 24 hour period.


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

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

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

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery
Procedure Eff Date: November 1, 2006
C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
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.).

### CHAPTER 11 (FL) 1 SCOPE OF SERVICES

**A. Living Supports- Family Living Services:**
The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):

19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and

**I. Healthcare Requirements for Family Living.**

3. **B.** Adult Nursing Services for medication oversight are required for all surrogate Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.

6. **Support Living- Family Living Provider Agencies** must 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 New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.

f. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

g. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;

v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

h. The Family Living Provider Agency must 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; and

i. Information from the prescribing pharmacy regarding medications must be kept in the
home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.

j. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.

iv. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments.

v. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.

vi. If the substitute care provider is a surrogate (not related by affinity or consanguinity)
Medication Oversight must be selected and provided.

CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication

Delivery: Supported Living Provider Agencies must 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, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

e. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

f. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;
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<tr>
<td>v. Documentation of any allergic reaction or adverse medication effect; and</td>
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<tr>
<td>vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</td>
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<tr>
<td>g. The Supported Living Provider Agency must 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; and</td>
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<tr>
<td>h. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs, and symptoms of adverse events and interactions with other medications.</td>
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</table>

**CHAPTER 13 (IMLS) 2. Service Requirements.** B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.


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

**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;
(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and

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</table>
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

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

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

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 <strong>Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy:</strong> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals’ Agency Record as required by standard for 2 of 39 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td><strong>Chapter 6 (CCS) 2. Service Requirements. E.</strong> The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual’s health status and medically related supports when receiving this service; 3. <strong>Agency Requirements: Consumer Records Policy:</strong> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</td>
<td><strong>Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:</strong> ◦ None found for 3/2014 – 8/2014 (#4)</td>
</tr>
<tr>
<td><strong>Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:</strong> All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</td>
<td><strong>Nutritional Evaluation</strong> ◦ Individual #7 - According to the IST section of the ISP the individual is required to have an evaluation. No evidence of evaluation found.</td>
</tr>
<tr>
<td><strong>Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:</strong> All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.</td>
<td><strong>L. Health Care Requirements for Family Living:</strong> 5. A nurse employed or contracted by the Family Living Supports provider must complete the e-</td>
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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: →


CHAT, the Aspiration Risk Screening Tool (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration.

a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first.

b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting.

c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization.

d. Other 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.

e. Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.

Chapter 12 (SL) 3. Agency Requirements:
D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

2. Service Requirements. L. Training and Requirements. 5. Health Related Documentation: For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following:

a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home;

b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated;

c. That the nurse has completed 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 must be documented whether they occur by phone or in person; and

d. Document for each individual that:

i. The individual has a Primary Care Provider (PCP);

ii. The individual receives an annual physical examination and other examinations as specified by a PCP;

iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;

iv. The individual receives a hearing test as specified by a licensed audiologist;

v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and

vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).

vii. The agency nurse will provide the individual’s team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually.

f. The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards.

Chapter 13 (IMLS) 2. Service Requirements:
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<tr>
<td>C. Documents to be maintained in the agency administrative office, include:</td>
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<tr>
<td>A. All assessments completed by the agency nurse, including the Intensive Medical Living Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall suffice;</td>
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<tr>
<td>F. Annual physical exams and annual dental exams (not applicable for short term stays);</td>
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<tr>
<td>G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for allowable exceptions for more frequent vision exam);</td>
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<tr>
<td>H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements);</td>
<td></td>
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<tr>
<td>I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange;</td>
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<tr>
<td>J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay);</td>
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<tr>
<td>L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay);</td>
<td></td>
</tr>
<tr>
<td>O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays);</td>
<td></td>
</tr>
<tr>
<td>P. Quarterly nursing summary reports (not applicable for short term stays);</td>
<td></td>
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<tr>
<td><strong>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</strong> A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible</td>
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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.

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff. 8/1/2010

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.

CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case
<p>| <strong>File for the Individual</strong>: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements...1, 2, 3, 4, 5, 6, 7, 8, |
| <strong>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</strong>: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Chapter 1. III. E. (1 - 4) |
| (1) Documentation of nursing assessment activities (2) Health related plans and (4) General Nursing Documentation |
| <strong>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination</strong> |
| (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. |</p>
<table>
<thead>
<tr>
<th>Tag # 1A27</th>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Incident Mgt. Late and Failure to Report</td>
<td>Based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 10 of 47 individuals.</td>
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### NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS

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

#### A. Duty to report:

1. All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.
2. All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.

#### B. Reporter requirement.

All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division’s hotline to report the incident.

#### C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:

1. **Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division’s toll-free hotline number 1-800-445-6242. Any consumer, Individual #2

   - Incident date 1/3/2014. Allegation was neglect and exploitation. Incident report was received on 1/3/2014. Failure to Report. IMB Late and Failure Report indicated incident of neglect and exploitation was “Unconfirmed.”

   - Incident date 2/24/2014. Allegation was neglect. Incident report was received on 3/6/2014. IMB issued a Failure to Report for Incident date 3/18/2014. Allegation was neglect. Incident report was received on 3/18/2014. Failure to Report. IMB Late and Failure Report indicated incident of neglect was “Unconfirmed.”

   - Incident date 4/21/2014. Allegation was neglect and exploitation. Incident report was received on 4/21/2014. Failure to Report. IMB Late and Failure Report indicated incident of neglect and exploitation was “Unconfirmed.”

   - Incident date 4/25/2014. Allegation was neglect. Incident report was received on 4/25/2014. Failure to Report. IMB Late and Failure Report indicated incident of neglect and exploitation was “Unconfirmed.”

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

(2) **Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division’s hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division’s abuse, neglect, and exploitation or report of death form consistent with the requirements of the division’s abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division’s abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct

<table>
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<tr>
<th>Individual #13</th>
<th>Incident date 6/6/2014. Allegation was Emergency Services. Incident report was received on 6/10/2014. IMB issued a Late Reporting for Emergency Services.</th>
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</thead>
<tbody>
<tr>
<td>Individual #19</td>
<td>Incident date 2/5/2014. Allegation was Emergency Services. Incident report was received on 2/10/2014. IMB issued a Late Reporting for Emergency Services.</td>
</tr>
<tr>
<td>Individual #20</td>
<td>Incident date 6/2/2014. Allegation was neglect. Incident report was received on 6/2/2014. Failure to Report. IMB Late and Failure Report indicated incident of neglect was “Unconfirmed.”</td>
</tr>
<tr>
<td>Individual #25</td>
<td>Incident date 1/20/2014. Allegation was Emergency Services. Incident report was received on 1/22/2014. IMB issued a Late Reporting for Emergency Services.</td>
</tr>
<tr>
<td>Individual #40</td>
<td>Incident date 12/5/2013. Allegation was abuse, neglect and exploitation and law enforcement involvement. Incident report was received on 12/6/2013. Failure to Report. IMB Late and Failure Report indicated incident of abuse, neglect and exploitation was “Unconfirmed.”</td>
</tr>
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</table>

**Individual #41**
knowledge of the incident participates in the preparation of the report form.

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

(4) **Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:
   (a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;
   (b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division’s direction, if necessary; and
   (c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057.

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

(6) **Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the

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<tr>
<th>Incident date</th>
<th>Allegation</th>
<th>Incident report</th>
<th>Failure to Report</th>
<th>IMB Late and Failure Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/5/2013</td>
<td>Abuse, neglect and exploitation</td>
<td>Received on 12/6/2013</td>
<td>Failure to Report</td>
<td>Imb Late and Failure Report indicated incident of abuse, neglect and exploitation was “Unconfirmed.”</td>
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Individual #42
- Incident date 3/3/2014. Allegation was abuse. Incident report was received on 3/3/2014. Failure to Report. IMB Late and Failure Report indicated incident of abuse was “Unconfirmed.”

Individual #43
- Incident date 3/31/2014. Allegation was abuse. Incident report was received on 4/2/2014. Late Reporting. IMB Late and Failure Report indicated incident of abuse and neglect was “Confirmed.”

Individual #44
- Incident date 4/29/2014. Allegation was neglect. Incident report was received on 4/29/2014. Failure to Report. IMB Late and Failure Report indicated incident of neglect was “Unconfirmed.”

Individual #45
- Incident date 5/25/2014. Allegation was abuse. Incident report was received on 5/29/2014. IMB issued a Failure to Report for abuse.

Individual #46
- Incident date 9/21/2014. Allegation was neglect. Incident report was received on 9/26/2014. IMB issued a Failure to Report for neglect.
consumer’s legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division’s investigative representative.

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

(8) Non-responsible reporter: Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation

Individual #47
- Incident date 4/14/2014. Allegation was Emergency Services. Incident report was received on 4/17/2014. IMB issued a Late Reporting for Emergency Services.

Individual #48
- Incident date 4/15/2014. Allegation was Emergency Services. Incident report was received on 4/17/2014. IMB issued a Late Reporting for Emergency Services.

Individual #49
- Incident date 4/19/2014. Allegation was Emergency Services. Incident report was received on 4/23/2014. IMB issued a Late Reporting for Law Enforcement Involvement.

Individual #50
- Incident date 5/5/2014. Allegation was Emergency Services. Incident report was received on 5/14/2014. IMB issued a Late Reporting for Law Enforcement Involvement
### Tag # 1A27.2
Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider

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<tr>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Based on record review, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 32 Individuals.</td>
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</tbody>
</table>

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

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

**A. Duty to report:**
1. All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers.
2. All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety.

**B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division’s hotline to report the incident.

**C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:**
1. **Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division’s toll-free hotline.

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**Survey on-site residential visit of Individual #4 on 12/9/2014 at 5:00 PM Surveyors observed the following:**

When Surveyors arrived to the residence and began to conduct a record review and interviews the surveyors immediately noticed the home was cluttered. As the Surveyors completed an observation of the home surveyors noted live cockroaches in the kitchen area and on the living room walls. When Surveyors went into the bathroom Surveyors found the toilet had feces in and around it and the toilet seat was broken. It was also noted during this observation that the bathroom and kitchen cabinets were broken. The face was missing from four kitchen drawers. One kitchen cabinet was hanging from a hinge. Two bathroom drawers were off track and one bathroom cabinet was hanging from a hinge. When the Surveyors entered Individual #4’s bedroom, Surveyors found the individual’s bed on the floor. Surveyors noted batteries that were not inserted in the smoke detector.

**As a result of what was observed the following incident(s) was reported:**

Individual #4
- A State Incident Report of Neglect, was filed on December 9th, 2014. Incident report was

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

(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division’s hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division’s abuse, neglect, and exploitation or report of death form consistent with the requirements of the division’s abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division’s abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct
knowledge of the incident participates in the preparation of the report form.

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

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

(a) develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;

(b) be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division’s direction, if necessary; and

(c) provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division’s website at [http://dhi.health.state.nm.us](http://dhi.health.state.nm.us); otherwise it may be submitted by faxing it to the division at 1-800-584-6057.

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

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

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

(8) **Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation.
<table>
<thead>
<tr>
<th>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</td>
<td>Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers’ Property, for 4 of 36 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>E. Consumer and guardian orientation packet: Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer’s file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.</td>
<td>• Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#2, 21, 25, 33)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Tag # 1A29</td>
<td>Complaints / Grievances Acknowledgement</td>
<td>Standard Level Deficiency</td>
</tr>
<tr>
<td>------------</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>NMAC 7.26.3.6 A</td>
<td>These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</td>
<td>Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 36 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
</tr>
<tr>
<td>NMAC 7.26.3.13 Client Complaint Procedure Available.</td>
<td>A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>NMAC 7.26.4.13 Complaint Process: A. (2).</td>
<td>The service provider's complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider’s complaint or grievance procedure</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 36 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:

- Grievance/Complaint Procedure Acknowledgement (#21)
<table>
<thead>
<tr>
<th>Tag # 1A31</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Rights/Human Rights</td>
<td>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>A. A service provider shall not restrict or limit a client's rights except:</td>
<td>Based on record review and/or interview, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 32 Individuals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</td>
<td>A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</td>
<td>No documentation was found regarding Human Rights Approval for the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</td>
<td>• Physical Restraint. No evidence found of Human Rights Committee approval. (Individual #36)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:
- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

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

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

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

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least
five years from the completion of each individual’s Individual Service Plan.

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

B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency’s Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Tag # 1A33.1</th>
<th>Board of Pharmacy - License</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual 6. Display of License and Inspection Reports</td>
<td>Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 24 residences:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>A. The following are required to be publicly displayed:</td>
<td>Individual Residence:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>□ Current Custodial Drug Permit from the NM Board of Pharmacy</td>
<td>• Current Custodial Drug Permit from the NM Board of Pharmacy (#31)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # LS06 / 6L06</td>
<td>Standard Level Deficiency</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
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<td>-----------</td>
<td></td>
</tr>
<tr>
<td><strong>Family Living Requirements</strong></td>
<td>Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 4 of 20 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>

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

- DDSD Approval for Subcontractor
  - Individual #7 - Not Current.
  - Individual #11 - Not Current.
  - Individual #15 - Not Current.
  - Individual #28 - Not Current.

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

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**Tag # LS06 / 6L06**

**Family Living Requirements**

**Standard Level Deficiency**

Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 4 of 20 individuals.

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

- DDSD Approval for Subcontractor
  - Individual #7 - Not Current.
  - Individual #11 - Not Current.
  - Individual #15 - Not Current.
  - Individual #28 - Not Current.

**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: →
b. Review implementation and the effectiveness of therapy, healthcare, PBSP, Behavior Crisis Intervention Plan (BCIP), MERP, and Comprehensive Aspiration Risk Management Plan (CARMP) plans if applicable;
c. Assist with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator or other IDT members; and
d. Monitor the Assistive Technology Inventory to ensure that needed adaptive equipment, augmentative communication and assistive technology devices are available and functioning properly.


**CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES**

A. **Support to Individuals in Family Living:** The Family Living Services Provider Agency shall provide and document:

(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:

(a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and

(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.

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.


CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS

D. Scope of DDSD Agreement

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

NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER ELIGIBLE PROVIDERS:

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

(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.
<table>
<thead>
<tr>
<th>Tag # LS13 / 6L13</th>
<th>Community Living Healthcare Reqts.</th>
<th>Condition of Participation Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</strong> 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.</td>
<td>After an analysis of the evidence it has been determined that there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 17 of 32 individuals receiving Community Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
</tbody>
</table>
| **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. | • **Annual Physical** (#4, 35)  
• **Dental Exam**  
  o Individual #1 - As indicated by collateral documentation reviewed, exam was completed on 3/17/2014. Follow up was to be completed in 6 months. No evidence of follow-up found.  
  o Individual #3 - As indicated by collateral documentation reviewed, the exam was completed on 10/31/2012. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.  
  o Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.  
  o Individual #9 - As indicated by collateral documentation reviewed, the exam was completed on 4/25/2013. As indicated by the DDSD file matrix, Dental Exams are to |
| Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 | Provider: State your Plan of Correction for the deficiencies cited in this tag here: →  |
| **Chapter 11 (FL) 3. Agency Requirements:**  
D. **Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →  |
| **Chapter 12 (SL) 3. Agency Requirements:**  
D. **Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. |  |
CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING

G. Health Care Requirements for Community Living Services.

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

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

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

   a. Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

   b. Vision Exam

      - Individual #10 - As indicated by collateral documentation reviewed, the exam was completed on 3/1/2012. Follow-up was to be completed in 4 months. No evidence of follow-up found.

      - Individual #15 - As indicated by collateral documentation reviewed, exam was completed on 7/31/2014. Follow-up was to be completed in 4 months. No evidence of follow-up found.

      - Individual #32 - As indicated by the DDSD file matrix Vision Exams are to be conducted annually. No evidence of exam was found.

   c. Dental Exams

      - Individual #10 - As indicated by collateral documentation reviewed, the exam was completed on 3/1/2012. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.

      - Individual #15 - As indicated by collateral documentation reviewed, exam was completed on 7/31/2014. Follow-up was to be completed in 4 months. No evidence of follow-up found.

      - Individual #32 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.
b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.

(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.

(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.

(5) That the physical property and grounds are free of hazards to the individual’s health and safety.

(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:

(a) The individual has a primary licensed physician;
(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;
(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;
(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and
(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).

Individual #15 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.

Individual #28 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.

Individual #31 - As indicated by collateral documentation reviewed, exam was completed on 7/5/2013. Follow-up was to be completed in 1 year. No evidence of follow-up found.

Individual #32 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.

- **Auditory Exam**
  - Individual #6 - As indicated by history and physical reviewed, exam was to be completed yearly. No evidence of exam found.

- **Prostate Specific Antigen (PSA)**
  - Individual #6 - As indicated by history and physical reviewed, exam was to be completed yearly. No evidence of exam found.

- **Bone Density Exam**
  - Individual #9 - As indicated by collateral documentation reviewed, exam was completed on 2/3/2011. Follow-up was to be completed in 2 years. No evidence of follow-up found.
- **Blood Levels**
  - Individual #9 - As indicated by collateral documentation reviewed, lab work was ordered on 9/2/2014 for Thyroid Stimulating Hormone. Follow-up was to be completed in 2 months. No evidence of follow-up found.

- **Review of Psychotropic Medication**
  - Individual #25 - According to exam dated 4/16/2014 Individual is to have a medication review every 3 months. No evidence was found for the following time frame to indicate they were completed 4/16/2014 - 7/31/2014.

- **Involuntary Movement Evaluations**
  - None found 4/16/2014 - 7/31/2014 for Quetiapine (#25)

- **Follow up for Anxiety/Panic Attack**
  - Individual #20 - As indicated by collateral documentation reviewed. Individual was seen for an anxiety/panic attack on 9/6/2014. Follow-up was to be completed in 3 - 5 days. No evidence of follow-up found.

- **Follow up for Diabetes and Depression**
  - Individual #24 - As indicated by collateral documentation reviewed, exam was completed on 4/2/2014. Follow-up was to be completed on 7/4/2014 for depression and diabetes. No evidence of follow-up found.

- **Neurology**
  - Individual #29 - As indicated by collateral documentation reviewed, exam was completed on 10/1/2013. Follow-up was to be completed in 1 year. No evidence of follow-up found.
<table>
<thead>
<tr>
<th>Lab Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #34 - As indicated by collateral documentation reviewed, Lab work was ordered on 5/22/2014 for Urinalysis. No evidence of follow-up found.</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports - Family Living Services: 1. Family Living Services providers must assure that each individual’s residence is maintained to be clean, safe and comfortable and accommodates the individuals’ daily living, social and leisure activities. In addition the residence must:</td>
</tr>
<tr>
<td>j. Maintain basic utilities, i.e., gas, power, water and telephone;</td>
</tr>
<tr>
<td>k. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;</td>
</tr>
<tr>
<td>l. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;</td>
</tr>
<tr>
<td>m. Have a general-purpose first aid kit;</td>
</tr>
<tr>
<td>n. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;</td>
</tr>
<tr>
<td>o. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year;</td>
</tr>
<tr>
<td>p. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Provider:</td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>
| }
consistent with the Assisting with Medication Delivery training or each individual’s ISP; and

q. Have 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 must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports-Supported Living Services: 1. Supported Living Provider Agencies must assure that each individual’s residence is maintained to be clean, safe, and comfortable and accommodates the individual’s daily living, social, and leisure activities. In addition the residence must:

a. Maintain basic utilities, i.e., gas, power, water, and telephone;

b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;

c. Ensure water temperature in home does not exceed safe temperature (110°F);

d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;

e. Have a general-purpose First Aid kit;

f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and

Administrative training or each individual’s ISP (#27, 33, 36)

- 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, 33, 36)

Note: The following Individuals share a residence:

- #17, 21
- #2, 25, 35
- #33, 36
- #6, 23

Family Living Requirements:

- Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#4)

- General-purpose first aid kit (#4)

- Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#31, 32)

- 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 (#4, 19, 32)

- Accessible written procedures for emergency placement and relocation of individuals in the
| each individual has the right to have his or her own bed; | 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 (#4, 31, 32) |
| g. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift; |  |
| h. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual’s ISP; and |  |
| i. Have 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 must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. |  |

**CHAPTER 13 (IMLS) 2. Service Requirements R. Staff Qualifications: 3. Supervisor Qualifications And Requirements:**

S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies.
T Each residence shall have a blood borne pathogens kit as applicable to the residents’ health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home.

U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions.

V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees.


CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS

L. Residence Requirements for Family Living Services and Supported Living Services
<table>
<thead>
<tr>
<th>Tag # 6L25.1</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Requirements (Physical Environment – SL/FL)</td>
<td>Based on observation, the Agency did not 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 32 Supported Living and Family Living residences.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td><strong>Family Living Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>During on-site residential visit of Individual #4 on 12/9/2014 at 5:00 PM</strong> Surveyors observed the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When Surveyors arrived to the residence and begun to conduct a record review and interviews the surveyors immediately notice the home was cluttered. As the Surveyors completed an observation of the home surveyors noted live cockroaches in the kitchen area and on the living room walls. When Surveyors went into the bathroom Surveyors found the toilet had feces in and around it and the toilet seat was broken. It was also noted during this observation that the bathroom and kitchen cabinets were broken. The face was missing from four kitchen drawers. One kitchen cabinet was hanging from a hinge. Two bathroom drawers were off track and one bathroom cabinet was hanging from a hinge. When the Surveyors entered Individual #4’s bedroom, Surveyors found the individual’s bed on the floor. Surveyors noted batteries that were not inserted in the smoke detector.</td>
<td></td>
</tr>
</tbody>
</table>

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

(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.

(3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP.

(4) Living and Dining Areas shall
   (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests;
   (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and
   (c) Provide environmental accommodations based on the unique needs of the individual.

(5) Kitchen area shall:
   (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day;
   (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
(c) Water temperature is required to be maintained at a safe level to both prevent 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.
### Service Domain: Medicaid Billing/Reimbursement – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

<table>
<thead>
<tr>
<th>Tag # 544</th>
<th>Adult Habilitation Reimbursement</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 3 of 5 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<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>
<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>
<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>
<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>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>MAD-MR: 03-59 Eff 1/1/2004</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual #9</td>
<td>August 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 112 units of Adult Habilitation (T2021 U1) from 8/17/2014 through 8/30/2014. Documentation received accounted for 109 units.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>September 2014</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• The Agency billed 186 units of Adult Habilitation (T2021 U1) from 8/31/2014 through 9/13/2014. Documentation received accounted for 125 units.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>October 2014</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• The Agency billed 180 units of Adult Habilitation (T2021 U1) from 9/28/2014 through 10/11/2014. Documentation received accounted for 147 units.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Individual #29</td>
<td>September 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 264 units of Adult Habilitation (T2021 U1) from 8/31/2014 through 9/13/2014. Documentation received accounted for 252 units.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Individual #23</td>
<td>August 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.15.2.DDW.11686880.3&5.RTN.01.14.079

Page 128 of 146
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 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.

<table>
<thead>
<tr>
<th>Month</th>
<th>A. Billable Unit</th>
<th>B. Billable Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>October</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The Agency billed 208 units of Adult Habilitation (T2021 U4) from 8/3/2014 through 8/16/2014. Documentation received accounted for 198 units.

- The Agency billed 208 units of Adult Habilitation (T2021 U4) from 8/17/2014 through 8/30/2014. Documentation did not contain the required elements on 8/28/2014. Documentation received accounted for 164 units. One or more of the following elements was not met:
  - Start and end time of each service encounter or other billable service interval.

September 2014

- The Agency billed 208 units of Adult Habilitation (T2021 U4) from 9/1/2014 through 9/13/2014. Documentation received accounted for 191 units.

- The Agency billed 208 units of Adult Habilitation (T2021 U4) from 9/14/2014 through 9/27/2014. Documentation did not contain the required elements on 9/27/2014. Documentation received accounted for 194 units. One or more of the following elements was not met:
  - Start and end time of each service encounter or other billable service interval.

October 2014

- The Agency billed 208 units of Adult Habilitation (T2021 U4) from 10/12/2014 through 10/25/2014. Documentation received accounted for 168 units.
<table>
<thead>
<tr>
<th>Tag # IS30</th>
<th>Customized Community Supports Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 6 (CCS) 4. REIMBURSEMENT</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A. Required Records:</strong> All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed.</td>
<td></td>
</tr>
<tr>
<td><strong>1. 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 Human Services Department (HSD). For each unit billed, the record shall contain the following:</strong></td>
<td></td>
</tr>
<tr>
<td>a. Date, start and end time of each service encounter or other billable service interval;</td>
<td></td>
</tr>
<tr>
<td>b. A description of what occurred during the encounter or service interval; and</td>
<td></td>
</tr>
<tr>
<td>c. The signature or authenticated name of staff providing the service.</td>
<td></td>
</tr>
<tr>
<td><strong>B. Billable Unit:</strong></td>
<td></td>
</tr>
<tr>
<td>1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.</td>
<td></td>
</tr>
<tr>
<td>2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Standard Level Deficiency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 8 of 14 individuals.</td>
</tr>
</tbody>
</table>

| **Individual #7** |
| **October 2014** |
| - The Agency billed 152 units of Customized Community Supports (Individual) (H2021 HB U1) from 10/1/2014 through 10/11/2014. Documentation received accounted for 124 units. |

| **Individual #14** |
| **September 2014** |
| - The Agency billed 198 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/31/2014 through 9/27/2014. Documentation received accounted for 190. |

| **Individual #15** |
| **October 2014** |
| - The Agency billed 128 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2014 through 9/27/2014. Documentation received accounted for 112 units. One or more of the following elements was not met: |

| **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:** |
| Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group.

4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD.

5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G).

6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee.

C. **Billable Activities:**
1. All DSP activities that are:
   a. Provided face to face with the individual;
   b. Described in the individual’s approved ISP;
   c. Provided in accordance with the Scope of Services; and
   d. Activities included in billable services, activities or situations.

2. Purchase of tuition, fees, and/or related materials associated with adult education

| Start and end time of each service encounter or other billable service interval. |
| Individual #17 | October 2014 |
| The Agency billed 220 units of Customized Community Supports (Group) (T2021 U1 U4) from 10/12/2014 through 10/25/2014. Documentation received accounted for 208 units. |

| Individual #19 | August 2014 |
| The Agency billed 74 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/3/2014 through 8/12/2014. Documentation received accounted for 68 units. |

| September 2014 |
| The Agency billed 140 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/9/2014 through 9/13/2014. Documentation received accounted for 45 units. |

| Individual #24 | August 2014 |
| The Agency billed 120 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/12/2014 through 8/16/2014. Documentation received accounted for 100 units. |

| October 2014 |
| The Agency billed 120 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/28/2014 through 10/10/2014. |
opportunities as related to the ISP Action Plan and Outcomes, not to exceed $550 including administrative processing fee.

3. Customized Community Supports can be included in ISP and budget with any other services.

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>Date</th>
<th>Details</th>
</tr>
</thead>
</table>
| September 2014 | The Agency billed 224 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2014 through 9/27/2014. Documentation did not contain the required elements on 9/16/2014 and 9/22/2014. Documentation received accounted for 156 units. One or more of the following elements was not met:  
  - The signature or authenticated name of staff providing the service. |
| October 2014 | The Agency billed 256 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/28/2014 through 10/11/2014. Documentation did not contain the required elements on 10/10/2014 and 10/11/2014. Documentation received accounted for 192 units. One or more of the following elements was not met:  
  - Start and end time of each service encounter or other billable service interval. |
| August 2014  | The Agency billed 168 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/3/2014 through 8/16/2014. Documentation did not contain the required elements on 8/5, 6, 7, 11, 12 15, 2014. Documentation received accounted for 120 units. One or more of the following elements was not met:  
  - The signature or authenticated name of staff providing the service. |
The Agency billed 176 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/17/2014 through 8/30/2014. Documentation did not contain the required elements on 8/18, 19, 20, 21, 22, 28, 29, 2014. Documentation received accounted for 96 units. One or more of the following elements was not met:
- The signature or authenticated name of staff providing the service.

September 2014
The Agency billed 192 units of Customized Community Supports (Individual) (H2021 HB U1) from 8/31/2014 through 9/13/2014. Documentation did not contain the required elements on 9/2, 3, 5, 2014. Documentation received accounted for 144 units. One or more of the following elements was not met:
- The signature or authenticated name of staff providing the service.

The Agency billed 144 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/14/2014 through 9/27/2014. Documentation did not contain the required elements on 9/17, 19, 22, 24, 25, 26, 2014. Documentation received accounted for 96 units. One or more of the following elements was not met:
- The signature or authenticated name of staff providing the service.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>LS26 / 6L26</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supported Living Reimbursement</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 12 individuals.</td>
</tr>
</tbody>
</table>

**A.** Supported Living Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity, and clinical necessity of services furnished to individuals who are currently receiving services. The Supported Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed.

3. The documentation of the billable time spent with an individual must be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record must contain the following:

   a. Date, start and end time of each service encounter or other billable service interval;

   b. A description of what occurred during the encounter or service interval;

   c. The signature or authenticated name of staff providing the service;

   d. The rate for Supported Living is based on categories associated with each individual's NM DDW Group; and

   e. A non-ambulatory stipend is available for those who meet assessed need requirement.

**B. Billable Units:**

---

**Individual #2**  
August 2014

- The Agency billed 7 units of Supported Living (T2033 UJ U1) from 8/21/2014 through 8/27/2014. Documentation did not contain the required elements on 8/23/2014 and 8/24/2014. Documentation received accounted for 5 units. One or more of the following elements was not met:
  - Date of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

**Individual #34**  
August 2014

- The Agency billed 1 units of Supported Living (T2016 HB U6) on 8/30/2014. Documentation did not contain the required elements on 8/30/2014. Documentation received accounted for 0 units. One or more of the required elements was not met:
  - No documentation 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: →
1. The billable unit for Supported Living is based on a daily rate. A day is determined based on whether the individual was residing in the home at midnight.

2. The maximum allowable billable units cannot exceed three hundred forty (340) calendar days per ISP year or one hundred seventy (170) calendar days per six (6) months.


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

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.

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

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

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.

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

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

A. Reimbursement for Supported Living Services

<table>
<thead>
<tr>
<th>1</th>
<th>(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.</th>
</tr>
</thead>
</table>
| 2 | (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 | (3) **Non-Billable Activities**

<p>| (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. |</p>
<table>
<thead>
<tr>
<th>Tag # LS27 / 6L27</th>
<th>Family Living Reimbursement</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</td>
<td><strong>CHAPTER 11 (FL) 4. REIMBURSEMENT A.</strong> Family Living Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Family Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed.</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 20 individuals.</td>
<td><strong>State your Plan of Correction for the deficiencies cited in this tag here:</strong> →</td>
</tr>
<tr>
<td><strong>Individual #7</strong> October 2014</td>
<td>• The Agency billed 28 units of Family Living (T2033 HB) from 10/9/2014 through 11/5/2014. Documentation received accounted for 23 units.</td>
<td><strong>Individual #15</strong> October 2014</td>
<td>• The Agency billed 27 units of Family Living (T2033 HB) from 10/9/2014 through 10/19/2014. Documentation received accounted for 11 units.</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>
<td></td>
</tr>
</tbody>
</table>

1. The documentation of the billable time spent with an individual must be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record must contain the following:

   a. Date, start and end time of each service encounter or other billable service interval;

   b. A description of what occurred during the encounter or service interval; and

   c. The signature or authenticated name of staff providing the service.

2. From the payments received for Family Living services, the Family Living Agency must:

   a. Provide a minimum payment to the contracted primary caregiver of $2,051 per month; and
b. Provide or arrange up to seven hundred fifty (750) hours of substitute care as sick leave or relief for the primary caregiver.

B. Billable Units:

1. The billable unit for Living Supports - Family Living is based on a daily rate. A day is determined based on whether the individual was residing in the home at midnight.

2. The maximum allowable billable units cannot exceed three hundred forty (340) days per ISP year or one hundred seventy (170) days per six (6) months.

Billable Activities: Any activities which DSP provides in accordance with the Scope of Services for Living Supports which are not listed in non-billable services, activities or situations below.

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.

CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION
B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for
reimbursement from the HSD. For each unit billed, the record shall contain the following:

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

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES
B. Reimbursement for Family Living Services
(1) 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.
(2) Billable Activities shall include:
   (a) Direct support provided to an individual in the residence any portion of the day;
   (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
   (c) Any other activities provided in accordance with the Scope of Services.
(3) Non-Billable Activities shall include:
   (a) The Family Living Services Provider Agency may not bill the for room and board;
   (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
(c) Family Living services may not be billed for the same time period as Respite.
(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.

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,

Your request for a Reconsideration of Findings was received on April 9, 2015. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

**Regarding Tag # 1A11.1**

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Training Document Request Form, Transportation Training for Direct Support Personnel (DSP) #266, 293, 319, 336, 347, 349, 350, 438 and 439 was not found and requested from and signed by agency staff (signature illegible) on 12/11/2014. The agency was given the opportunity to reconcile any documentation to verify training and a final copy of the QMB Training Document Request Form, still listing these trainings as missing, was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the findings. The remaining citations noted in this tag were not disputed.

**Regarding Tag # 1A20**

Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Training Document Request Form, numerous missing and/or expired trainings were requested from and signed by agency staff (signature illegible) on 12/11/2014. The agency was given the opportunity to reconcile any documentation to verify training and a final copy of the QMB Training Document Request Form, still listing these trainings as missing and/or expired, was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the findings.
Regarding Tag # 1A25
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Training Document Request Form, Caregiver Criminal History Screening Letters for DSP #385, 250, 252, 271, 317, 320, 321 and 413 were requested from and signed by agency staff (signature illegible) on 12/11/2014. The agency was given the opportunity to reconcile any documentation to verify CCHS Letters were available and addressed to the agency. A final copy of the QMB Training Document Request Form, still listing these items as missing and/or not addressed to the agency, was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the findings. Furthermore, per NMAC 7.1.9, the agency must maintain records of the Notification of Clearance for all employed caregivers and a letter is mailed to the agency separately to satisfy this requirement.

Regarding Tag # 1A26
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Training Document Request Form, completion of the Employee Abuse Registry (EAR) prior to employment for DSP #353 was requested from and signed by agency staff (signature illegible) on 12/11/2014. The agency was given the opportunity to reconcile any documentation from the document request form and a final copy of the QMB Training Document Request Form, still listing the EAR check as completed late for the above employees was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the finding.

Regarding Tag # 1A28.1
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Training Document Request Form, missing and/or expired Incident Management System (IMS) Trainings for DSP #214, 224, 247, 376, 409 and 435 and Service Coordinators (SC) #445 and 446 were requested from and signed by agency staff (signature illegible) on 12/11/2014. The agency was given the opportunity to reconcile any documentation to verify IMS training and a final copy of the QMB Training Document Request Form, still listing these trainings as missing and/or expired, was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the findings. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A36
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Training Document Request Form Service Coordinator Trainings, were missing and/or expired for SC #449 and 450 and were requested from and signed by agency staff (signature illegible) on 12/11/2014. The agency was given the opportunity to reconcile any documentation to verify training and a final copy of the QMB Training Document Request Form, still listing these trainings as missing and/or expired, was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the findings. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A37
Determination: The IRF committee is modifying the original finding in the report of findings. In reviewing the QMB Training Document Request Form, it was found that DSP #439 was cited
incorrectly. The finding for DSP #439 will be removed. However, based on the QMB Training Document Request Form, Individual Specific Training was not found for DSP #253, 266, 312, 350, 375, 381, 385, 387, 416, 419, 420, 421, 422, 425, 433, 439, 442 and SC #446 which was requested from and signed by agency staff (signature illegible) on 12/11/2014. You are required to complete the remainder of your Plan of Correction as previously indicated as the agency was given the opportunity to reconcile any documentation to verify training and a final copy of the QMB Training Document Request Form, still listing these trainings as missing, was provided to the agency and signed by Diane Nunn on 12/12/2014. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A09
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Residential Case File Survey Tool, the findings at the residence were reviewed with Kathryn Orona. Ms. Orona signed on 12/10/2014 acknowledging that items listed as missing, not current and/or incorrect on the Residential Case File Survey Tool were accurate as documented. The remaining citation noted in this tag were not disputed.

Regarding Tag # 1A27
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Any items cited in this tag will have to be addressed directly with the Incident Management Bureau (IMB), as the deficiencies identified in this tag are directly from the Incident Management Late and Failure report. The remaining citations noted in this tag were not disputed.

Regarding Tag # LS06/6L06
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the QMB Document Request Form, the DDSD Subcontractor Approval for Individuals #7 and 15 were requested from and signed by agency staff (signature illegible) on 12/09/2014. The agency was given the opportunity to reconcile any missing documentation from the document request form and a final copy of the QMB Document Request Form, still listing these items as missing, was provided to the agency and signed by Diane Nunn on 12/12/2014. No documentation was provided to surveyors while on-site to refute the findings. The remaining citations noted in this tag were not disputed.

Regarding Tag # LS27/6L27
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on review of the QMB survey tools, Individual #15 was cited incorrectly. Citation for Individual #15 will be removed. The remaining citations noted in this tag were not disputed.

This concludes the Informal Reconsideration of Finding process. The IRF process is separate and apart from the Informal Dispute Resolution process or the Medicaid Fair Hearing process when DOH sanctions are imposed on a provider.

Thank you.
Respectfully,
Crystal Lopez-Beck

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

Q.15.2.DDW.11686880.3&5.RTN.12.15.114
Date: June 24, 2015

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

E-mail Address: thenewbeginnings@gmail.com
Region: Metro and Southwest
Survey Date: December 8-12, 2014
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Supported Living, Family Living); Inclusion Supports (Customized Community Supports) and Other (Customized In-Home Supports)  
2007: Community Living (Supported Living, Family Living) and Community Inclusion (Adult Habilitation)
Survey Type: Routine

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

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

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

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

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

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

Tony Fragua
Health Program Manager
Quality Management Bureau/DHI

Q.15.2.DDW.11686880.3&5.RTN.07.15.175