Date: October 1, 2012

To: Connie Kalter, Executive Director
Provider: New Pathways, Inc.
Address: 11024 Montgomery NE #343
State/Zip: Albuquerque, New Mexico 87111

E-mail Address: conniekalter@msn.com

Region: Metro, Northeast, Southeast & Southwest
Survey Date: August 13 – 17, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Family Living) & Community Inclusion Supports (Adult Habilitation)
Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Martinez de Berenger, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, MSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Kalter;

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

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

Compliance with all Conditions of Participation.

SUSANA MARTINEZ, GOVERNOR
CATHARINE D. TORRES, M.D., CABINET SECRETARY

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

QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012
This determination is based on your agency’s compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

**Plan of Correction:**
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency’s compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

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

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

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

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

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

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

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

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

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

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

Tony Fragua, BFA

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

Entrance Conference Date: August 13, 2012

Present:

**New Pathways, Inc.**
Connie Kalter, Executive Director
Debra King, Assistant Director/Service Coordinator/Incident Management Coordinator
Melissa Escarcida, Service Coordinator
Traci Hinsley, Administration Assistant

**DOH/DHI/QMB**
Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor

Exit Conference Date: August 16, 2012

Present:

**New Pathways, Inc.**
Connie Kalter, Executive Director
Melissa Escarcida, Service Coordinator
Donna Schorr, Service Coordinator
Debra King, Assistant Director/Service Coordinator/Incident Management Coordinator
Teddi Tabacek, Service Coordinator
Nathan Carpio, Residential Supervisor
Traci Hinsley, Administration Assistant

**DOH/DHI/QMB**
Tony Fragua, BFA, Team Lead/Healthcare Surveyor
Erica Nilsen, BA, Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor
Marti Madrid, LBSW, Healthcare Surveyor
Stephanie Martinez de Berenger, MPA, Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor

**DDSD - Metro Regional Office**
Rose Mary Williams, Social & Community Service Coordinator

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Total Homes Visited
- Number: 15
  - Supported Homes Visited
    - Number: 3
  - Family Homes Visited
    - Number: 12

Administrative Locations Visited
- Number: 1

Total Sample Size
- Number: 18
  - 18 - Non-Jackson Class Members
  - 3 - Supported Living
  - 15 - Family Living
  - 7 - Adult Habilitation
Persons Served Records Reviewed Number: 18
Persons Served Interviewed Number: 15
Persons Observed Number: 3 (Three Individuals were not available for an interview during the on-site survey)
Direct Support Personnel Interviewed Number: 18
Direct Support Personnel Records Reviewed Number: 72
Service Coordinator Records Reviewed Number: 4
Administrative Files Reviewed
- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

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

Initial Submission of the Plan of Correction Requirements
1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of
Correction Form and received by QMB within ten (10) business days from the date you received the
report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-
699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD
Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
b. Fax to 505-222-8661, or
c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has
been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.

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

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

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

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

**POC Document Submission Requirements**

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

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

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

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

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

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

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

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

- **“Compliance with Conditions of Participation”**
The QMB determination of “Compliance with Conditions of Participation,” indicates that a provider is in compliance with all ‘Conditions of Participation,’ (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. 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.

- **“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 one (1) to three (3) ‘Conditions of Participation.’ 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).

Providers receiving a repeat determination of ‘Partial-Compliance’ for repeat deficiencies of CoPs may be referred by the Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- **“Non-Compliant 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 and/or has:
  - Four (4) Conditions of Participation out of compliance.
  - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  - Any finding of actual harm or Immediate Jeopardy.

The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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.
Attachment C

Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

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

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

The following limitations apply to the IRF process:

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
**Agency:** New Pathway Inc. - Metro, Northeast, Southeast & Southwest Regions  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living Supports (Supported Living & Family Living) & Community Inclusion Supports (Adult Habilitation)  
**Monitoring Type:** Routine Survey  
**Date of Survey:** August 13 – 17, 2012

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Service Plans: ISP Implementation</strong> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
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<table>
<thead>
<tr>
<th>Tag # 1A08 Agency Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
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</thead>
</table>
| Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 5 of 18 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:  
- Positive Behavioral Crisis Plan (#8 & 18)  
- Speech Therapy Plan (#16)  
- Physical Therapy Plan (#12)  
- Documentation of Guardianship/Power of Attorney (#13) | 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: →
<p>| | | |</p>
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<tbody>
<tr>
<td>(1)</td>
<td>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;</td>
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<td>(2)</td>
<td>The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</td>
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<td>(3)</td>
<td>Progress notes and other service delivery documentation;</td>
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<td>(4)</td>
<td>Crisis Prevention/Intervention Plans, if there are any for the individual;</td>
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<tr>
<td>(5)</td>
<td>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;</td>
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<tr>
<td>(6)</td>
<td>When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</td>
<td></td>
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<td>(7)</td>
<td>Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</td>
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<tr>
<td>(8)</td>
<td>The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</td>
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<tr>
<td>(a)</td>
<td>Complete file for the past 12 months;</td>
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<td>(b)</td>
<td>ISP and quarterly reports from the current and prior ISP year;</td>
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<td>(c)</td>
<td>Intake information from original admission to services; and</td>
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<tr>
<td>(d)</td>
<td>When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</td>
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</tbody>
</table>
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:  A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1 Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 1 of 7 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Adult Habilitation Progress Notes/Daily Contact Logs</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</td>
<td>• Individual #8 - None found for 6/13/2012 - 6/19/2012</td>
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<tr>
<td>(3) Progress notes and other service delivery documentation;</td>
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</tbody>
</table>

QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012
<table>
<thead>
<tr>
<th>Tag # 1A32 &amp; 6L14 ISP Implementation</th>
<th>Standard Level Deficiency</th>
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</thead>
<tbody>
<tr>
<td>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 7 of 18 individuals.</td>
</tr>
<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
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<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td>Administrative Files Reviewed:</td>
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<tr>
<td>Provider:</td>
<td></td>
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<tr>
<td></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>Provider:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
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<tr>
<td>Individual #15</td>
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<tr>
<td>• Live Outcome: &quot;... will clean the family vehicles monthly,&quot; is to be completed 1 time per month. Outcome/Action Step was not being completed at the required frequency for 4/2012.</td>
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<tr>
<td>• Develop Relationships/ Have Fun Outcome: &quot;... will participate in the Bowling Special Olympic events and sing the Star Spangled Banner at the games,&quot; is to be completed 1 time weekly. Outcome/Action Step was not being completed at the required frequency for 4/2012 - 6/2012.</td>
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<tr>
<td>Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
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<tr>
<td>Individual #10</td>
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<tr>
<td>• Review of Agency’s documented Outcomes &amp; Action Steps does not match the current ISP Outcomes and Action Steps.</td>
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</table>
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]

### Residential Files Reviewed:

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

Individual #8
- None found for 8/1/2012 – 8/13/2012

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

Individual #2
- None found regarding: Live Outcome; Action Step; “… will operate his T.V., turning it on and off practicing a minimum of 2x/wk until he is able to perform the function independently,” for 8/1 - 14, 2012.

- None found regarding: Live Outcome; Action Step; “… will operate his T.V., changing stations, practicing a minimum of 2x/wk until he is able to perform the function independently,” for 8/1 - 14, 2012.

- None found regarding: Live Outcome; Action Step; “… will regulate the volume on his T.V., practicing a minimum of 2x/wk until he is able to perform the function independently,” for 8/1 - 14, 2012.

- None found regarding: Fun Outcome; Action Step; “Each morning, … will get his ID and tickets out and have them ready for the bus when it comes to pick him up, independently,” for 8/1 - 14, 2012.
• None found regarding: Fun Outcome; Action Step; “…will show his ID to the bus driver and give the bus driver his tickets when he gets on the bus each morning, independently,” for 8/1 - 14, 2012.

• None found regarding: Fun Outcome; Action Step; “…will strap himself into his seatbelt on the bus, every morning when he goes home,” for 8/1 - 14, 2012.

Individual #6
• None found regarding: Live Outcome; “…will assist in preparing one meal once a week through July 2013,” for 8/1 - 15, 2012.

Individual #9
• None found regarding: Live Outcome; “I will experience 6 new community activities this year and develop a scrapbook of my experiences,” for 8/1 - 13, 2012.

• None found regarding: Work/Education/Volunteer Outcome; Action Step; “…will be presented with choices of outings,” is to be completed 1 time weekly. Outcome/Action Step was not being completed at the required frequency for 8/1 - 13, 2012.

• None found regarding: Work/Education/Volunteer Outcome; Action Step; “…will research choices,” is to be completed 1 time weekly. Outcome/Action Step was not being completed at the required frequency for 8/1 - 13, 2012.

• None found regarding: Work/Education/Volunteer Outcome; Action Step; “…will choose an activity,” is to be
<table>
<thead>
<tr>
<th>Step</th>
<th>Outcome/Action Step</th>
<th>Frequency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>None found regarding:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work/Education/Volunteer Outcome; Action Step; “…will organize the group for outings/activities,”</td>
<td>1 time weekly</td>
<td>Not being completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for 8/1 - 13, 2012.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>None found regarding:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work/Education/Volunteer Outcome; Action Step; “…will participate in the activity,”</td>
<td>1 time weekly</td>
<td>Not being completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for 8/1 - 13, 2012.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>None found regarding:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Work/Education/Volunteer Outcome; Action Step; “…will practice turning computer on and off,”</td>
<td>2 times weekly</td>
<td>Not being completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for 8/1 - 13, 2012.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>None found regarding:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work/Education/Volunteer Outcome; Action Step; “…will practice using the pad and mouse,”</td>
<td>2 times weekly</td>
<td>Not being completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for 8/1 - 13, 2012.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>None found regarding:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work/Education/Volunteer Outcome; Action Step; “…will access the internet,”</td>
<td>2 times weekly</td>
<td>Not being completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>for 8/1 - 13, 2012.</td>
<td></td>
</tr>
<tr>
<td>Step was not being completed at the required frequency for 8/1 - 13, 2012.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Individual #11  
- None found regarding: Live Outcome; “I will independently go on strolls w/ my electric wheel chair,” is to be completed 1 time weekly. Outcome/Action Step was not being completed at the required frequency for 8/1 - 13, 2012. |
| Individual #14  
- None found for 8/1/2012 – 8/13/2012. |
### Tag # 6L14 Residential Case File

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 11 of 18 Individuals receiving Family Living Services and Supported Living Services.</td>
</tr>
<tr>
<td>The following was not found, incomplete and/or not current:</td>
</tr>
<tr>
<td>• <strong>Current Emergency &amp; Personal Identification Information</strong></td>
</tr>
<tr>
<td>○ Did not contain Pharmacy Information (#10)</td>
</tr>
<tr>
<td>○ Did not contain Health Plan Information (#10 &amp; 13)</td>
</tr>
<tr>
<td>○ Did not contain Physician’s Information (#12)</td>
</tr>
<tr>
<td>• Positive Behavioral Plan (#7, 8 &amp; 18)</td>
</tr>
<tr>
<td>• Positive Behavioral Crisis Plan (#7, 8, 12 &amp; 18)</td>
</tr>
<tr>
<td>• Occupational Therapy Plan (#1)</td>
</tr>
<tr>
<td>• Physical Therapy Plan (#4 &amp; 12)</td>
</tr>
<tr>
<td>• <strong>Special Health Care Needs</strong></td>
</tr>
<tr>
<td>○ Nutritional Plan (#14 &amp; 16)</td>
</tr>
<tr>
<td>○ Aspiration Risk Assessment Tool (#4)</td>
</tr>
<tr>
<td>• <strong>Health Care Plans</strong></td>
</tr>
<tr>
<td>○ Body Mass Index (#8)</td>
</tr>
<tr>
<td>• <strong>Progress Notes/Daily Contacts Logs:</strong></td>
</tr>
<tr>
<td>○ Individual #1 - None found for 8/1, 11, 12 &amp; 13, 2012</td>
</tr>
</tbody>
</table>

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

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

---

**Tag # 6L14 Residential Case File**

**Standard Level Deficiency**

Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 11 of 18 Individuals receiving Family Living Services and Supported Living Services. The following was not found, incomplete and/or not current:

- **Current Emergency & Personal Identification Information**
  - Did not contain Pharmacy Information (#10)
  - Did not contain Health Plan Information (#10 & 13)
  - Did not contain Physician’s Information (#12)
- Positive Behavioral Plan (#7, 8 & 18)
- Positive Behavioral Crisis Plan (#7, 8, 12 & 18)
- Occupational Therapy Plan (#1)
- Physical Therapy Plan (#4 & 12)
- **Special Health Care Needs**
  - Nutritional Plan (#14 & 16)
  - Aspiration Risk Assessment Tool (#4)
- **Health Care Plans**
  - Body Mass Index (#8)
- **Progress Notes/Daily Contacts Logs:**
  - Individual #1 - None found for 8/1, 11, 12 & 13, 2012

**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: →
(6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
(7) Physician’s or qualified health care providers written orders;
(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);
(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (a) The name of the individual;
   (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
   (c) Diagnosis for which the medication is prescribed;
   (d) Dosage, frequency and method/route of delivery;
   (e) Times and dates of delivery;
   (f) Initials of person administering or assisting with medication; and
   (g) An explanation of any medication irregularity, allergic reaction or adverse effect.
   (h) For PRN medication an explanation for the use of the PRN must include:
      (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
      (ii) Documentation of the effectiveness/result of the PRN delivered.
   (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual’s home and an updated

<table>
<thead>
<tr>
<th>Individual #</th>
<th>Date Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>#11</td>
<td>None found for 8/4/2012 – 8/12/2012</td>
</tr>
<tr>
<td>#14</td>
<td>None found for 8/1/2012 – 8/13/2012</td>
</tr>
</tbody>
</table>
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.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Qualified Providers</strong> – 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.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Tag # 1A11.1 Transportation Training</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 7 of 72 Direct Support Personnel.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</strong> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards...</td>
<td><strong>No documented evidence was found of the following required training:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy</strong> <strong>Eff Date:</strong> March 1, 2007</td>
<td>• Transportation (DSP #105, 108, 109, &amp; 110)</td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td><strong>II. POLICY STATEMENTS:</strong></td>
<td><strong>When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:</strong></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 employment and before working alone with an individual receiving services. The training shall address at least the following:</td>
<td>• DSP #84 stated, “No, I don’t fall into that category.”</td>
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<tr>
<td>1. Operating a fire extinguisher</td>
<td>• DSP #96 stated, “No, I’ve haven’t had anything like that.”</td>
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<tr>
<td>2. Proper lifting procedures</td>
<td>• DSP #106 stated, “No.”</td>
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<tr>
<td>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)</td>
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<td>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines</td>
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</tbody>
</table>
for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 29 of 72 Direct Support Personnel.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</strong> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
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<tr>
<td><strong>C. Orientation and Training Requirements:</strong> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
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<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
<td>• Pre-Service (DSP #49 &amp; 110)</td>
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<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td>• Foundation for Health &amp; Wellness (DSP #49, 78 &amp; 110)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for</td>
<td>• Person-Centered Planning (1-Day) (DSP #110)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• First Aid (DSP #43, 47, 48, 59, 70, 71, 83, 89, 91, 92, 94, 100, 102, 105, 107, 108, 109 &amp; 110)</td>
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<tr>
<td></td>
<td>• CPR (DSP #48, 70, 76, 89, 91, 92, 94, 102, 103, 105, 106, 107, 108, 109 &amp; 110)</td>
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<td></td>
<td>• Assisting With Medication Delivery (DSP #50, 55, 63, 65, 80, 92 &amp; 105)</td>
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<td></td>
<td>• Participatory Communication &amp; Choice Making (DSP #71 &amp; 110)</td>
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<td></td>
<td>• Advocacy 101 (DSP #110)</td>
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<td></td>
<td>• Positive Behavior Supports Strategies (DSP #110)</td>
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<tr>
<td></td>
<td>• Teaching &amp; Support Strategies (DSP #110)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
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<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
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<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>
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<tr>
<td>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
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<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>
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<tr>
<td>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
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<tr>
<td>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
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<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>
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<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>
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</tr>
<tr>
<td>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.</td>
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</table>
### Tag # 1A22  
**Agency Personnel Competency**  

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on interview, the Agency failed to ensure that training competencies were met for 1 of 18 Direct Support Personnel.</td>
</tr>
</tbody>
</table>

**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.

**F. Qualifications for Direct Service Personnel:** The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:

1. Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;

2. Direct service personnel shall have the ability to read and carry out the requirements in an ISP;

3. Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual.

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

- DSP #104 stated, "I don’t see any." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Gastrointestinal/Constipation and Pain. (Individual #12)

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

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

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:

(a) Initial comprehensive personnel status report (name, date of hire, Social Security number category) on all required personnel to be submitted to DDSD Statewide Training Database within the first ninety (90) calendar days of providing services;

(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and

(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.

Department of Health (DOH) Developmental
<table>
<thead>
<tr>
<th>Disabilities Supports Division (DDSD) Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Title: Training Requirements for</td>
</tr>
<tr>
<td>Direct Service Agency Staff Policy - Eff.</td>
</tr>
<tr>
<td>March 1, 2007 - II. POLICY STATEMENTS:</td>
</tr>
<tr>
<td>A. Individuals shall receive services from</td>
</tr>
<tr>
<td>competent and qualified staff.</td>
</tr>
</tbody>
</table>

| QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012 |

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1A26</td>
<td>BUSY on-line/Employee Abuse Registry</td>
<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 employee prior to employment. Such documentation shall include the date the inquiry was made and the date the registry was completed. Based on record review, the Agency failed to maintain documentation in the employee’s personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 2 of 76 Agency Personnel.  
The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:  
**Direct Support Personnel (DSP):**  
- #61 – Date of hire 3/16/2012, completed 4/30/2012.  
- #110 – Date of hire 7/1/2011, completed 9/23/2011.  | 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:  |  |   |
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.


**Chapter 1.IV. General Provider Requirements. D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and
Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| **NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:**  
**A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.  
**D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.  
**Policy Title:** Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007  
**II. POLICY STATEMENTS:**  
A. Individuals shall receive services from |
| Based on record review, the Agency failed to provide documentation verifying completion of Incident Management Training for 11 of 76 Agency Personnel.  
**Direct Support Personnel (DSP):**  
- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#57, 58, 59, 60, 65, 89, 98, 105, 108, 109 & 110) |
| 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: → |

QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012

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>Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 2 of 4 Service Coordinators.</td>
</tr>
<tr>
<td><strong>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</strong> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</td>
</tr>
<tr>
<td><strong>C. Orientation and Training Requirements:</strong> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td></td>
</tr>
<tr>
<td>(1) Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and</td>
<td>• Person Centered Planning (2-Day) (SC #115)</td>
</tr>
<tr>
<td><strong>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 Provider:</strong></td>
<td>• Promoting Effective Teamwork (SC #115)</td>
</tr>
<tr>
<td></td>
<td>• ISP Critique (SC #112)</td>
</tr>
<tr>
<td></td>
<td>• Sexuality for People with Developmental Disabilities (SC #112)</td>
</tr>
<tr>
<td></td>
<td>• Health Wellness Coordination (SC #112)</td>
</tr>
</tbody>
</table>

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

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

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QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012

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;
<table>
<thead>
<tr>
<th>Tag # 1A37 Individual Specific Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 6 of 76 Agency Personnel.</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of personnel records found no evidence of the following:</td>
</tr>
<tr>
<td><strong>Direct Support Personnel (DSP):</strong></td>
<td><strong>Direct Support Personnel (DSP):</strong></td>
</tr>
<tr>
<td></td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>
requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
**Standard of Care**

**Deficiencies**

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

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

**CMS Assurance – 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.

### Tag # 1A03 CQI System

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to implement their Continuous Quality Management System as required by standard.</td>
</tr>
</tbody>
</table>

- Review of the findings identified during the on-site survey (Aug 13 – 17, 2012) and as reflected in this report of findings the Agency had multiple deficiencies noted, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.

**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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**QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012**

(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;
(6) Quality and completeness documentation; and
(7) Trends in individual and guardian satisfaction.

7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:
E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:

(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
(4) community based service providers
providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
**Tag # 1A09  Medication Delivery (MAR) - Routine Medication**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>
**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;  
Medication Administration Records (MAR) were reviewed for the months of May, June & August 2012.  
Based on record review, 5 of 18 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:  
Individual #1  
May 2012  
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:  
- Bensaclin Topical gel 1/5% (1 time daily)  
June 2012  
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:  
- Bensaclin Topical gel 1/5% (1 time daily)  
August 2012  
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:  
- Toprimate 25mg (2 times daily) – Blank 8/8 (4 PM); 8/9, 10, 11 & 12 (7 AM & 4 PM)  
- Minocyclin 100mg (2 times daily) – Blank 8/7, 8, 9, 10, 11, 12 & 13 (10 AM & 11 PM)  
- Gabapentin 400mg (2 times daily) – Blank 8/9, 10, 11, 12 & 13 (8 AM & 12 PM)  
- Gabapentin 400mg (1 times daily) – Blank 8/8, 9, 10, 11, 12 & 13 (11 PM) | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

3. The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;
4. MARs are not required for individuals participating in Independent Living who self-administer their own medications;
5. Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

**NMAC 16.19.11.8 MINIMUM STANDARDS:**
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;
   (ii) Date given;
   • Buspirone 15mg (3 times daily) – Blank 8/8 (1 PM & 11 PM); 8/9, 10, 11, 12 & 13 (8 AM, 1 PM & 11 PM)

Individual #13
May 2012
As indicated by the Medication Administration Records the individual is to take Folic Acid 800mg (1 time daily). According to the Physician’s Orders Folic Acid 800mg is to be taken 1 time daily. Medication Administration Record & Physician’s Orders do not match.

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

June 2012
As indicated by the Medication Administration Records the individual is to take Folic Acid 800mg (1 time daily). According to the Physician’s Orders Folic Acid 800mg is to be taken 1 time daily. Medication Administration Record & Physician’s Orders do not match.

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

August 2012
Medication Administration Records did not contain the route of administration for the following medications:
• Risperidone 1mg (1 time daily)

Individual #15
May 2012
Medication Administration Records did not
(iii) Drug product name;  
(iv) Dosage and form;  
(v) Strength of drug;  
(vi) Route of administration;  
(vii) How often medication is to be taken;  
(viii) Time taken and staff initials;  
(ix) Dates when the medication is discontinued or changed;  
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual  
D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Medication Administration Records did not contain the strength of the medication which is to be given:
- Omega 3 Fish Oil (1 time daily)

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Omega 3 Fish Oil (1 time daily)
- Complete Multivitamin (1 time daily)
- Vitamin C 1000mg (1 time daily)

June 2012
Medication Administration Records did not contain the strength of the medication which is to be given:
- Omega 3 Fish Oil (1 time daily)

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Omega 3 Fish Oil (1 time daily)
- Complete Multivitamin (1 time daily)
- Vitamin C 1000mg (1 time daily)

August 2012
Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Omega 3 Fish Oil (1 time daily)
- Complete Multivitamin (1 time daily)
- Vitamin C 1000mg (1 time daily)

Individual #17  
June 2012
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Systane Teardrops (3 times daily) – Blank 6/11, 12, 13, 14 & 15 (1 PM); 6/16 (1 PM & 5 PM); 6/17 & 30 (9 AM & 1 PM)

Individual #18
June 2012
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Lactulose 10gr/15ml (1 time daily) – Blank 6/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 & 30 (AM)

Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications:
- Lactulose 10gr/15ml (1 time daily)
<table>
<thead>
<tr>
<th>Tag # 1A09.1 Medication Delivery - PRN Medication</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 3 of 18 Individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>
| 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. | Individual #3
May 2012
No evidence of documented Signs/Symptoms were found for the following PRN medication:
• Hydrocodone/APAP 5mg/500mg – PRN – 5/2, 3, 4, 5, 12, 13, 14, 22, 26, 27, 29, 30 & 31 (given 1 time) | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| 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. | No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
• Hydrocodone/APAP 5mg/500mg – PRN – 5/2, 3, 4, 5, 12, 13, 14, 22, 26, 27, 29, 30 & 31 (given 1 time) | |
| (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: | Individual #14
June 2012
No evidence of documented Signs/Symptoms were found for the following PRN medication:
• Pink Bismuth Suspension – PRN – 6/23 & 24 (given 1 time) | |
| (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; | No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
• Pink Bismuth Suspension – PRN – 6/23 & 24 (given 1 time) | |
| (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; | Individual #15
May 2012
Medication Administration Records did not contain the exact amount to be used in a 24 | |
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

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

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

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

NMAC 16.19.11.8 MINIMUM STANDARDS:
A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:
(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:

<table>
<thead>
<tr>
<th>Hour period</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen 325mg (PRN)</td>
<td></td>
</tr>
<tr>
<td>Imodium (PRN)</td>
<td></td>
</tr>
<tr>
<td>Mylagen (PRN)</td>
<td></td>
</tr>
<tr>
<td>Chloraseptic Throat Spray (PRN)</td>
<td></td>
</tr>
<tr>
<td>Guiatuss (PRN)</td>
<td></td>
</tr>
<tr>
<td>Pepto-Bismul (PRN)</td>
<td></td>
</tr>
<tr>
<td>Milk of Magnesia (PRN)</td>
<td></td>
</tr>
</tbody>
</table>

Medication Administration Records did not contain the dosage of the medication which is to be given:

- Imodium (PRN)
- Mylagen (PRN)
- Chloraseptic Throat Spray (PRN)
- Guiatuss (PRN)
- Pepto-Bismul (PRN)
- Milk of Magnesia (PRN)

June 2012 Medication Administration Records did not contain the exact amount to be used in a 24 hour period:

- Acetaminophen 325mg (PRN)
- Imodium (PRN)
- Mylagen (PRN)
| (i) Name of resident; | • Chloraseptic Throat Spray (PRN) |
| (ii) Date given; | • Guiauss (PRN) |
| (iii) Drug product name; | • Pepto-Bismul (PRN) |
| (iv) Dosage and form; | • Milk of Magnesia (PRN) |
| (v) Strength of drug; | Medication Administration Records did not contain the dosage of the medication which is to be given: |
| (vi) Route of administration; | • Imodium (PRN) |
| (vii) How often medication is to be taken; | • Mylagen (PRN) |
| (viii) Time taken and staff initials; | • Chloraseptic Throat Spray (PRN) |
| (ix) Dates when the medication is discontinued or changed; | • Guiauss (PRN) |
| (x) The name and initials of all staff administering medications. | • Pepto-Bismul (PRN) |

### Model Custodial Procedure Manual

**D. Administration of Drugs**

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

### Department of Health

**Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006**

**F. PRN Medication**

3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure

| August 2012 | Medication Administration Records did not contain the exact amount to be used in a 24 hour period: |
| August 2012 | • Acetaminophen 325mg (PRN) |
| | • Imodium (PRN) |
| | • Mylagen (PRN) |
| | • Chloraseptic Throat Spray (PRN) |
| | • Guiauss (PRN) |
| | • Pepto-Bismul (PRN) |
| | • Milk of Magnesia (PRN) |
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.

Medication Administration Records did not contain the dosage of the medication which is to be given:
- Imodium (PRN)
- Mylagen (PRN)
- Chloraseptic Throat Spray (PRN)
- Guiatuss (PRN)
- Pepto-Bismul (PRN)
- Milk of Magnesia (PRN)
**Procedure Title:**
**Medication Assessment and Delivery**

**Procedure Eff Date:** November 1, 2006

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

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

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
<table>
<thead>
<tr>
<th>Tag #1A11</th>
<th>Transportation Policy &amp; Procedure</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to have a written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</strong> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Review of Agency’s policies and procedures indicated the following elements were not found:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>G. Transportation:</strong> Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled “Client Transportation Safety”. The policy and procedures must address at least the following topics:</td>
<td>(2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1) Drivers’ requirements,</td>
<td>(4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions,</td>
<td>(5) Emergency Plans, including vehicle evacuation techniques,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) Vehicle maintenance and safety inspections,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5) Emergency Plans, including vehicle evacuations techniques,</td>
<td></td>
<td></td>
</tr>
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QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012

51
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy

Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007

II. POLICY STATEMENTS:
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:

1. Operating a fire extinguisher
2. Proper lifting procedures
3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)
4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
<table>
<thead>
<tr>
<th>Tag # 1A15.2 &amp; 5I09 - Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>

**CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

**Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities**

(a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training:

- (i) Community living services provider agency;
- (ii) Private duty nursing provider agency;
- (iii) Adult habilitation provider agency;
- (iv) Community access provider agency; and
- (v) Supported employment provider agency.

(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual’s Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these.

Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 18 individuals.

The following were not found, incomplete and/or not current:

- **Comprehensive Aspiration Risk Management Plan**
  - Individual #1, 13 & 16

- **Quarterly Nursing Review of HCP/Crisis Plans:**
  - None found for 7/2011 - 6/2012 (#13)
  - None found for 6/2011 - 5/2012 (#16)

- **Special Health Care Needs:**
  - Nutritional Plan
    - Individual #18 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - G-Tube Protocol
    - Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - Aspiration
    - Individual #16 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
  - Crisis Plans/Medical Emergency Response Plans
    - Tube Feed

**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:
assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

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

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

(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency.

- Oral Care
  - Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

- Aspiration
  - Individual #16 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.
method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.
(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):
(a) Each healthcare plan must include a statement of the person’s healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain
a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.

c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.

g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.
(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

(4) General Nursing Documentation
   (a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.
   (b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.

CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS
B. IDT Coordination
   (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

   (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.
Department of Health Developmental Disabilities Supports Division Policy.
Medical Emergency Response Plan Policy
MERP-001 eff.8/1/2010

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
Tag # 1A27.2 Duty to Report - IRs Filed During On-Site and/or IRs Not Reported by Provider

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
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</thead>
</table>
| 7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: A. Duty To Report:  
(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.  
(2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:  
(a) an environmental hazardous condition, which creates an immediate threat to life or health; or  
(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.  
(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.  
B. Notification:  
(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| Based on record review, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 19 Individuals.  
During the on-site survey August 13 - 17, 2012 surveyors found evidence of 1 internal agency incident reports, which had not been reported to DHI and/or APS/CYFD, as required by regulation.  
The following internal incidents were reported as a result of the on-site survey:  
Individual #19  
- Incident date 1/1/2012 (8:30 AM). Type of incident identified was neglect. Incident was brought to the attention of the Agency by Surveyors. Incident report was filed on 8/17/2012 by DHI/QMB. |
correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division’s website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.

(2) Division Incident Report Form and Notification by Community Based Service Providers: The community based service provider shall report incidents utilizing the division’s incident report form consistent with the requirements of the division’s incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division’s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Incident Mgt. System - Parent/Guardian Training</th>
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</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
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<tr>
<td>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
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<tr>
<td>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and 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 or misappropriation. The licensed health care facility and 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>
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<tr>
<td>Based on record review, the Agency failed to 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 1 of 18 individuals.</td>
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<td>Provider:</td>
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<td>State your Plan of Correction for the deficiencies cited in this tag here:</td>
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<td>Provider:</td>
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<tr>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
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<tr>
<td>Tag # 6L06 Family Living Requirements</td>
<td>Standard Level Deficiency</td>
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</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to complete all DDSD requirements for approval of each direct support provider for 1 of 18 individuals. The following was not found, not current and/or incomplete:</td>
</tr>
<tr>
<td><strong>(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:</strong></td>
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<tr>
<td>(a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and</td>
<td></td>
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<tr>
<td>(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.</td>
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<tr>
<td><strong>B. Home Studies.</strong> The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</td>
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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: →

Provider: 

| | |
| | |
CHAPTER 1. I. PROVIDER AGENCY
ENROLLMENT PROCESS
D. Scope of DDSD Agreement

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

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

ELIGIBLE PROVIDERS:
I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards.
(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.
### Tag # 6L13 Community Living Healthcare Reqts.

**Standard Level Deficiency**

Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 18 individuals receiving Community Living Services.

The following was not found, incomplete and/or not current:

- **Dental Exam**
  - Individual #3 - As indicated by collateral documentation reviewed, exam was scheduled for 5/12/2012. No evidence of exam results was found.

- **Vision Exam**
  - Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam results was found.

- **Colonoscopy**
  - Individual #4 - As indicated by collateral documentation reviewed, exam was ordered by Primary Care Physician at annual physical on 11/7/2011. No evidence of exam results was found.

- **Review of Psychotropic Medication**
  - Individual #13 - As indicated by collateral documentation reviewed, the Individual is to have a medication review every 6-months. No evidence was found for 10/2011 – 4/2012 to indicate medication review was completed.

- **Abnormal Involuntary Movement Screening or Tardive Dyskinesia**

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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: →

Provider:
detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.

b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.

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

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

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

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

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

<table>
<thead>
<tr>
<th>Screenings</th>
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<tbody>
<tr>
<td>• None found 8/2011 - 8/2012 for Risperidone (#13)</td>
</tr>
<tr>
<td>• None found 8/2011 - 8/2012 for Tradazone (#16)</td>
</tr>
<tr>
<td>• None found 8/2011 - 8/2012 for Risperdal (#16)</td>
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</tbody>
</table>
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.
Tag # 6L25 Residential Health & Safety (Supported Living & Family Living)

<table>
<thead>
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<tbody>
<tr>
<td><strong>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</strong></td>
</tr>
<tr>
<td><strong>L. Residence Requirements for Family Living Services and Supported Living Services</strong></td>
</tr>
<tr>
<td>(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:</td>
</tr>
<tr>
<td>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</td>
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<tr>
<td>(b) General-purpose first aid kit;</td>
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<tr>
<td>(c) When applicable due to an individual’s health status, a blood borne pathogens kit;</td>
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<tr>
<td>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</td>
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<tr>
<td>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</td>
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<tr>
<td>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</td>
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<tr>
<td>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and</td>
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<tr>
<td>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding;</td>
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### Standard Level Deficiency

After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.

Based on observation, the Agency failed to ensure that each individual’s residence met all requirements within the standard for 12 of 15 Supported Living & Family Living residences.

The following items were not found, not functioning or incomplete:

**Supported Living Requirements:**
- 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 (#7 & 8)
- 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 (#7 & 8)

**Family Living Requirements:**
- Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#3, 6 & 17)
- Accessible telephone numbers of poison control centers located within the line of sight

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QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012


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: →
unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

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<tbody>
<tr>
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<td>of the telephone (#12 &amp; 13)</td>
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<tr>
<td></td>
<td><strong>Note: Individuals #12 &amp; 13 share a residence</strong></td>
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<tr>
<td></td>
<td>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#3, 6, 9, 10, 11, 12, 13, 14, 15, 16, 17 &amp; 18)</td>
</tr>
<tr>
<td></td>
<td><strong>Note: Individuals #9 &amp; 11 share a residence as do Individuals #12 &amp; 13</strong></td>
</tr>
<tr>
<td></td>
<td>• 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 (#12, 13, 14 &amp; 18)</td>
</tr>
<tr>
<td></td>
<td><strong>Note: Individuals #12 &amp; 13 share a residence</strong></td>
</tr>
</tbody>
</table>

QMB Report of Findings – New Pathways, Inc. – Metro, Northeast, Southwest & Southeast Region – August 13 - 17, 2012


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<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Medicaid Billing/Reimbursement/Financial Accountability</strong></td>
<td><strong>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</strong></td>
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### Tag # 5I44 Adult Habilitation Reimbursement

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
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<tbody>
<tr>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 6 of 7 individuals.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

**Individual #2**

**May 2012**
- The Agency billed 97 units of Adult Habilitation (T2021 U2) from 5/2/2012 through 5/8/2012. Documentation received accounted for 95 units.
- The Agency billed 97 units of Adult Habilitation (T2021 U2) from 5/2/2012 through 5/8/2012. Documentation received accounted for 72 units.
- The Agency billed 73 units of Adult Habilitation (T2021 U2) from 5/2/2012 through 5/8/2012. Documentation received accounted for 48 units.

**June 2012**
- The Agency billed 100 units of Adult Habilitation (T2021 U2) from 5/30/2012 through 6/5/2012. Documentation received accounted for 97 units.
- The Agency billed 98 units of Adult Habilitation (T2021 U2) from 6/6/2012 through 6/12/2012. Documentation received accounted for 72 units.

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

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**MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

- 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.
- 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.

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

- The Agency billed 98 units of Adult Habilitation (T2021 U2) from 6/13/2012 through 6/19/2012. Documentation received accounted for 48 units.

Individual #4
April 2012
- The Agency billed 95 units of Adult Habilitation (T2021 U2) from 4/25/2012 through 5/1/2012. Documentation received accounted for 93 units.

Individual #7
May 2012
- The Agency billed 128 units of Adult Habilitation (T2021 U2) from 5/16/2012 through 5/22/2012. Documentation received accounted for 109 units.

June 2012
- The Agency billed 125 units of Adult Habilitation (T2021 U2) from 6/13/2012 through 6/19/2012. Documentation received accounted for 103 units.
- The Agency billed 120 units of Adult Habilitation (T2021 U2) from 6/20/2012 through 6/26/2012. Documentation received accounted for 110 units.

Individual #8
June 2012
- The Agency billed 33 units of Adult Habilitation (T2021 U2) from 6/6/2012 through 6/12/2012. Documentation received accounted for 29 units.
- The Agency billed 24 units of Adult Habilitation (T2021 U2) from 6/13/2012
through 6/19/2012. Documentation received accounted for 0 units. The following element was not met:
  ➢ No documentation found.

Individual #9
April 2012
• The Agency billed 94 units of Adult Habilitation (T2021 U2) from 4/18/2012 through 4/24/2012. Documentation received accounted for 93 units.

May 2012
• The Agency billed 117 units of Adult Habilitation (T2021 U2) from 5/9/2012 through 5/15/2012. Documentation received accounted for 116 units.

• The Agency billed 71 units of Adult Habilitation (T2021 U2) from 5/23/2012 through 5/29/2012. Documentation received accounted for 70 units.

June 2012
• The Agency billed 118 units of Adult Habilitation (T2021 U2) from 6/6/2012 through 6/12/2012. Documentation received accounted for 113 units.

• The Agency billed 137 units of Adult Habilitation (T2021 U2) from 6/20/2012 through 6/26/2012. Documentation received accounted for 124 units.

Individual #11
April 2012
• The Agency billed 116 units of Adult Habilitation (T2021 U1) from 4/4/2012 through 4/10/2012. Documentation received accounted for 115 units.
• The Agency billed 113 units of Adult Habilitation (T2021 U1) from 4/11/2012 through 4/17/2012. Documentation received accounted for 112 units.

• The Agency billed 105 units of Adult Habilitation (T2021 U1) from 4/18/2012 through 4/24/2012. Documentation received accounted for 104 units.

May 2012
• The Agency billed 113 units of Adult Habilitation (T2021 U1) from 5/2/2012 through 5/8/2012. Documentation received accounted for 112 units.

• The Agency billed 117 units of Adult Habilitation (T2021 U1) from 5/9/2012 through 5/15/2012. Documentation received accounted for 114 units.

• The Agency billed 114 units of Adult Habilitation (T2021 U1) from 5/16/2012 through 5/22/2012. Documentation received accounted for 110 units.

• The Agency billed 89 units of Adult Habilitation (T2021 U1) from 5/23/2012 through 5/29/2012. Documentation received accounted for 84 units.

June 2012
• The Agency billed 117 units of Adult Habilitation (T2021 U1) from 5/30/2012 through 6/5/2012. Documentation received accounted for 110 units.

• The Agency billed 118 units of Adult Habilitation (T2021 U1) from 6/6/2012
Documentation received accounted for 115 units.

- The Agency billed 93 units of Adult Habilitation (T2021 U1) from 6/13/2012 through 6/19/2012. Documentation received accounted for 86 units.
Dear Ms. Kalter,

Your request for a Reconsideration of Findings was received on October 16, 2012. 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 # 1A08**
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 document request form specific to items in the Administrative files, the documents needed to demonstrate compliance were requested prior to end of the survey and were not provided; furthermore the request form was signed by you, acknowledging the missing documents and the date which they were due.

**Regarding Tag # 1A08.1**
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 the information submitted to support your IRF the deficiency cited for Individual #8 will be removed. The remaining citations noted in tag were upheld (IRF for #9 did not contain a rationale or reason for dispute).

**Regarding Tag # 6L14**
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 documentation supplied, the Residential Interview and Case File Review Tool, the documents were requested from and signed by each service provider and not received prior to the end of the survey (residential visit). The remaining citations noted in tag 6L14 were not disputed.
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 document request form specific to training, the documents needed to demonstrate trainings had occurred were requested from and signed by New Pathways staff who failed to provide this information to the survey team by the end of the on-site survey (8/17/12). You also claim termination of employee #105 but provided no paperwork supporting this.

Regarding Tag # 1A20
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 the document request form specific to training, the documents needed to demonstrate trainings had occurred for Staff #89, 91, 94, 100 and 105 were requested from and signed by New Pathways staff who failed to provide the requested information to the survey team by the end of the survey.

Regarding Tag # 1A26
Determination: The IRF committee is removing the original finding from the report of findings.

Regarding Tag # 1A28.1
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. Deficiencies originally cited for Staff # 57, 58, 59, 60, and 65 will be removed. The citations for #89, 98, 105, 108, 109 and 110 will be upheld; as they were requested from and signed by New Pathways staff who failed to provide the requested information to the survey team by the end of the survey.

Regarding Tag # 1A37
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 deficiencies sited in the original report of findings and those upheld in the IRF the 1A03 citation for a functional QA/QI Plan will be upheld.

Regarding Tag # 1A03
Determination: The IRF committee is upholding the original finding in the report of findings. Based on the deficiencies sited in the original report of findings and those upheld in the IRF the 1A03 citation for a functional QA/QI Plan will be upheld.

Regarding Tag # 1A09
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 documentation supplied, deficiencies noted in tag 1A09 regarding Individual #13’s Folic Acid will be removed. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A15.2
Determination: The IRF committee is removing the original finding from the report of findings.

**Regarding Tag # 6L25**
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 documentation supplied the Residential Interview and Case File Review Tool and observation, the documents were requested from and signed by each service provider and not received prior to the end of the survey (residential visit).

**Regarding Tag # 5I44**
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 documentation supplied the following determinations have been made:

- Individual #2 – the original citation will be removed.
- Individual #4 – the original citation will be removed.
- Individual #7 – the original citation will be modified.
  (June 2012, 120 units of T2021 U2 will be upheld)
- Individual #8 – the original citation will be modified.
  (June 2012, 24 units of T2021 U2 will be upheld)
- Individual #9 – the original citation will be modified.
  (June 2012, 137 units of T2021 U2 will be upheld)
- Individual #11 – the original citation will be modified.
  (April 2012, 105 units of T2021 U1, and all citations for May 2012 will be upheld)

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,

Scott Good
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair

CC: Distribution List:  
DOH - Division of Health Improvement  
DOH - Developmental Disabilities Supports Division  
DOH - Office of Internal Audit  
HSD - Medical Assistance Division
Date: December 12, 2012

To: Connie Kalter, Executive Director

Provider: New Pathways, Inc.
Address: 11024 Montgomery NE #343
State/Zip: Albuquerque, New Mexico 87111

E-mail Address: conniekalter@msn.com

Region: Metro, Northeast, Southeast & Southwest
Survey Date: August 13 – 17, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Family Living) & Community Inclusion Supports (Adult Habilitation)
Survey Type: Routine

Dear Ms. Kalter;

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

The Plan of Correction process is now complete.

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

However, due to the initial late submission of your Plan of Correction, your agency has been referred to the Internal Review Committee (IRC). The IRC will be in contact with you about that referral and actions that need to be taken.

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

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

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

Sincerely,

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