Dear Ms. Roy:

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. In addition to your routine compliance survey an expanded survey was completed specific to the health and safety of Supported Living homes. The expanded survey was initiated during the routine survey as a result of observations of the Survey Team and from concerns voiced by agency personnel relating to the safety of residences. The following was found:

- Health and Safety of Individuals and their residences - QMB Findings: During the Expanded Survey the QMB conducted visits to 100% of the Supported Living residences operated by Optihealth Inc. Based on further observations and record reviews, no additional concerns or deficiencies were identified in this area due to the Expanded Survey.

After closely reviewing each of these areas the following Report of Findings will identify for you and your Agency each area in which there were deficiencies during the routine compliance survey. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider agreements. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Determination of Compliance:**

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

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

**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,

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

Entrance Conference Date: September 23, 2013

Present:

**Optihealth Inc.**
Chitra Roy, Executive Director

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor

Exit Conference Date: September 26, 2013

Present:

**Optihealth Inc.**
Chitra Roy, Executive Director
Susan White, Office Manager
Brenda Allen, Service Coordinator
Alaina DuPree, Administrative Assistant
E. Jeanie Miller, Nurse

**DOH/DHI/QMB**
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor

Administrative Locations Visited
Number: 2
- Administrative Office: 4620 Jefferson Lane NE, Suite A, Albuquerque, New Mexico 87109
- Adult Habilitation Site: 10800 Menaul Boulevard NE, Albuquerque, New Mexico 87112

Total Routine Sample Size
Number: 9

Total Health and Safety Only Sample Size
Number: 12

2 - Jackson Class Members
7 - Non-Jackson Class Members
9 - Supported Living
7 - Adult Habilitation
12 - Health and Safety visit only

Total Homes Visited
Number: 12
- Routine Survey Supported Living Homes Visited Number: 7
- Health and Safety Only Visits Number: 5

Persons Served Records Reviewed
Number: 9

Persons Served Interviewed
Number: 9

Direct Support Personnel Interviewed
Number: 21
- Routine Survey DSP Interviews Number: 13
- Health and Safety DSP Interviews Number: 8
Direct Support Personnel Records Reviewed Number: 90
Service Coordinator Records Reviewed Number: 2

Administrative Processes and Records Reviewed:

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

CC: Distribution List:

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

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

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

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

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

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

If you have questions about the Plan of Correction process, call the QMB Deputy Chief/Plan of Correction Coordinator at 505-222-8650 or email at Crystal.Lopez-Beck@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

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

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

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

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

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

Note: Instruction or in-service of staff alone may not be a sufficient plan of correction. This is a good first step toward correction, but additional steps 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 Deputy Chief/POC Coordinator, Crystal Lopez-Beck at 505-222-8650 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Crystal Lopez-Beck, Deputy Chief/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 NE, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.

6. QMB will notify you when your POC has been “approved” or “denied.”
   a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
   e. Please note that all POC correspondence will be sent electronically unless otherwise requested.

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

**POC Document Submission Requirements**

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

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. 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. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC. for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
   a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
   b. Copies of “void and adjust” forms submitted to Xerox State Healthcare, LLC. to correct all unjustified units identified and submitted for payment during your internal audit.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the 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.
Attachment B

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

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

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

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

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

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

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

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

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

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

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

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

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

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.
Attachment C

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

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

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

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

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

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

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

### Deficiencies

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Agency Case File</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A08</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 2 of 9 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></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.

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

(1) Emergency contact information, including the individual’s address, telephone number, names and telephone numbers of relatives,

- ISP Teaching and Support Strategies
  - Individual #8 - TSS not found for the following Action Steps:
  - Work/Learn Outcome Statement:
    - "Will develop a weekly schedule of daytime activities available in the community."
- Speech Therapy Plan (#1)

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Survey Report #: Q.14.1.DDW.D1889.5.001.RTN.01.310
or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;

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

(3) Progress notes and other service delivery documentation;

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

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

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

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

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

(a) Complete file for the past 12 months;

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

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

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

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

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
### Tag # 1A08.1
**Agency Case File - Progress Notes**

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

**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.

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

1. Progress notes and other service delivery documentation;

Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 9 Individuals. Review of the Agency individual case files revealed the following items were not found:

**Adult Habilitation Progress Notes/Daily Contact Logs**

- Individual #1 - None found 7/5/2013.
- Individual #10 - None found for 7/6, 13, 20 and 27, 2013.

**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: →

)}
<table>
<thead>
<tr>
<th><strong>Tag # 1A32 and 6L14</strong></th>
<th><strong>Standard Level Deficiency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Service Plan Implementation</strong></td>
<td><strong>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 9 individuals.</strong></td>
</tr>
</tbody>
</table>

C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.

D. The intent is to provide choice and obtain

Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:

**Residential Files Reviewed:**

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

Individual #3

- None found for 9/1 – 23, 2013.

| 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: | → |

| } |
opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]
<table>
<thead>
<tr>
<th>Tag # 5I11</th>
<th>Reporting Requirements</th>
<th>Community Inclusion Reports</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Provider Agency Reporting Requirements:</strong> All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual’s Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</td>
<td></td>
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<tr>
<td>(1) Identification and implementation of a meaningful day definition for each person served;</td>
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<td>(2) Documentation summarizing the following:</td>
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<tr>
<td>(a) Daily choice-based options; and</td>
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<tr>
<td>(b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP.</td>
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<tr>
<td>(3) Significant changes in the individual’s routine or staffing;</td>
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<tr>
<td>(4) Unusual or significant life events;</td>
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<tr>
<td>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</td>
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<td>(6) Record of personally meaningful community inclusion;</td>
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<td>(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and</td>
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<td>(8) Any additional reporting required by DDSD.</td>
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<tr>
<td>Based on record review, the Agency did not complete quarterly reports as required for 1 of 7 individuals receiving Community Inclusion services.</td>
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<tr>
<td>Review of the Agency individual case files revealed the following items were not found, and/or incomplete:</td>
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<tr>
<td><strong>Adult Habilitation Quarterly Reports</strong></td>
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<tr>
<td>• Individual #8 - None found for 9/2012 - 12/2012.</td>
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<tr>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</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>
</tbody>
</table>
Tag # 6L14  
Residential Case File  

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 9 Individuals receiving Supported Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

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

- **Current Emergency and Personal Identification Information**
  - None Found (#3)
  - Did not contain Physician Information (#6)

- **Positive Behavioral Plan (#3, 6)**

- **Positive Behavioral Crisis Plan (#3, 6)**

- **Speech Therapy Plan (#1)**

- **Special Health Care Needs**
  - Meal Time Plan (#1)
  - Nutritional Plan (#6)

- **Health Care Plans**
  - Body Mass Index (#9)
  - Diabetes (#4)
  - Falls (#4)
  - Glucose Monitor (#4)
  - Oral Care (#4, 8)
  - PRN Psychotropics (#4)
  - Neuroleptic Malignant Syndrome (#1)

- **Medical Emergency Response Plans**
  - Allergies (#4)

---

A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual’s home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual’s home, the complete and current confidential case file for each individual shall be maintained at the agency’s administrative site. Each file shall include the following:

1. Complete and current ISP and all supplemental plans specific to the individual;
2. Complete and current Health Assessment Tool;
3. Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician’s name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;
4. Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
5. Data collected to document ISP Action Plan implementation.
(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>Aspiration (#2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GERD (#4)</td>
</tr>
</tbody>
</table>
(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>Tag #6L17 Reporting Requirements (Community Living Reports)</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 did not complete written quarterly status reports for 1 of 9 individuals receiving Community Living Services.</td>
</tr>
<tr>
<td><strong>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</strong></td>
<td>Review of the Agency individual case files revealed the following items were not found, and/or incomplete:</td>
</tr>
<tr>
<td><strong>D. Community Living Service Provider Agency Reporting Requirements:</strong> All Community Living Support providers shall submit written quarterly status reports to the individual’s Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</td>
<td><strong>Supported Living Quarterly Reports:</strong></td>
</tr>
<tr>
<td>(1) Timely completion of relevant activities from ISP Action Plans</td>
<td><strong>(1) Individual #8 - None found for 9/2012 - 12/2012.</strong></td>
</tr>
<tr>
<td>(2) Progress towards desired outcomes in the ISP accomplished during the quarter;</td>
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</tr>
<tr>
<td>(3) Significant changes in routine or staffing;</td>
<td><strong>Provider:</strong></td>
</tr>
<tr>
<td>(4) Unusual or significant life events;</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and</td>
<td></td>
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<tr>
<td>(6) Data reports as determined by IDT members.</td>
<td><strong>Provider:</strong></td>
</tr>
<tr>
<td></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>


Survey Report #: Q.14.1.DDW.D1889.5.001.RTN.01.310
**Service Domain: Qualified Providers** – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.

<table>
<thead>
<tr>
<th>Tag # 1A11.1</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| Transportation Training | Based on record review the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 1 of 90 Direct Support Personnel. **No documented evidence was found of the following required training:**  
• Transportation (DSP #124) | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → | |

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

**II. POLICY STATEMENTS:**

1. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:  
   1. Operating a fire extinguisher  
   2. Proper lifting procedures  
   3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)  
   4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines...
for supporting individuals who may be unaware of safety issues involving traffic or 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>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 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. C. Orientation and Training Requirements: 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: (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 (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>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 3 of 90 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Foundation for Health and Wellness (DSP #121) • First Aid (DSP #60) • Assisting With Medication Delivery (DSP #60, 90)</td>
<td></td>
</tr>
<tr>
<td>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: →</td>
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</tbody>
</table>
Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.
F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.
G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.
H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
<table>
<thead>
<tr>
<th>Tag # 1A22 Agency Personnel Competency</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 interview, the Agency did not ensure training competencies were met for 3 of 21 Direct Support Personnel.</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td><strong>When DSP were asked if they received training on the Individual's Seizures, the following was reported:</strong></td>
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<tr>
<td>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</td>
<td>- DSP #80 stated, “No.” Per the Individual Specific Training Section of the ISP the individual has a diagnosis of seizures and requires DSP to be trained. (Individual #8)</td>
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<tr>
<td>(1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times;</td>
<td><strong>When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:</strong></td>
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<tr>
<td>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</td>
<td>- DSP #90 stated, “I don’t know what they work on.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #1)</td>
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<tr>
<td>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the</td>
<td>- DSP #80 stated, “I don’t see one.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #5)</td>
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<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td><strong>When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:</strong></td>
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<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td>- DSP #97 stated, “Yes, but I don’t know what they do. I have not been trained.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #10)</td>
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<tr>
<td>Department of Health (DOH) Developmental</td>
<td>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</td>
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<tr>
<td>(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</td>
<td>• DSP #80 stated, “Seizures and falls.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Oral Care. (Individual #8)</td>
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<tr>
<td>(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.</td>
<td>When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:</td>
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<tr>
<td>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</td>
<td>• DSP #90 stated, “Epi-pen, I believe that’s the only one.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration, and Neuroleptic Malignant Syndrome. (Individual #1)</td>
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<tr>
<td>(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;</td>
<td>When DSP were asked if the Individual had Bowel and Bladder issues and if so, what are they to monitor, the following was reported:</td>
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<tr>
<td>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</td>
<td>• DSP #80 stated, “Seizures and falls.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Anaphylactic Reaction. (Individual #8)</td>
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<tr>
<td>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</td>
<td>When DSP were asked if they received</td>
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</table>

DSP #80 stated, “Seizures and falls.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Oral Care. (Individual #8)

DSP #90 stated, “Epi-pen, I believe that’s the only one.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration, and Neuroleptic Malignant Syndrome. (Individual #1)

DSP #80 stated, “Seizures and falls.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Anaphylactic Reaction. (Individual #8)

DSP #90 stated, “He doesn’t require it.” According to the Electronic Comprehensive Health Assessment Tool, the Individual has bowel and bladder issues. (Individual #1)
| Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. | training on the Individual’s Meal Time Plans and what the plan covered, the following was reported:  
- DSP #90 stated, “I haven’t had training on his Aspiration.” As indicated by the Individual Specific Training section of the ISP the individual has a Meal Time Plan. (Individual #1)  
When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:  
- DSP #80 stated, “No.” According to the Electronic Comprehensive Health Assessment Tool, the Individual is allergic to Aspirin and Phenobarbital. (Individual #8) |
<table>
<thead>
<tr>
<th>Tag # 1A26</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
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</table>
| **Consolidated On-line Registry Employee Abuse Registry** | **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 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 |
| **NMAC 7.1.12.8** | Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 92 Agency Personnel.  
**The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:**  
**Direct Support Personnel (DSP):**  
- #62 – Date of hire 12/11/2012, completed 12/14/2012.  
- #100 – Date of hire 1/6/2013, completed 1/15/2013.  

**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: → |
having a substantiated registry-referred incident of abuse, neglect or exploitation.

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

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


**Chapter 1.IV. General Provider Requirements.**

D. **Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.
<table>
<thead>
<tr>
<th>Tag # 1A28.1</th>
<th>Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</strong></td>
<td>Based on record review and Interview, the Agency did not ensure Incident Management Training for 4 of 92 Agency Personnel.</td>
<td></td>
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<tr>
<td><strong>A. General:</strong> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
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<tr>
<td><strong>D. Training Documentation:</strong> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee’s employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative’s request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</td>
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</tr>
<tr>
<td><strong>Policy Title:</strong> Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>II. POLICY STATEMENTS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</tbody>
</table>
A. Individuals shall receive services from competent and qualified staff.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
**Service Domain: Health and Welfare** – The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| 1A03  | CQI System | Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard. Review of the Agency’s CQI Plan revealed the following:  
- Evidence found during the on-site survey and as reflected in this report of findings the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency. In addition, the Agency’s CQI Plan did not contain the following components:  
  1. Trends in achievement of individual outcomes in the Individual Service Plans;  
  2. Trends in medication and medical incidents leading to adverse health events;  
  3. Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;  
  4. Quality and completeness documentation provided by the Agency was not being used to successfully identify and improve systems within the agency. In addition, the Agency’s CQI Plan did not contain the following components:  
  1. Trends in achievement of individual outcomes in the Individual Service Plans;  
  2. Trends in medication and medical incidents leading to adverse health events;  
  3. Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;  
  4. Quality and completeness documentation |

**Standard of Care**

<table>
<thead>
<tr>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I. Continuous Quality Management System:</strong> Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to: (1) Individual access to needed services and supports; (2) Effectiveness and timeliness of implementation of Individualized Service Plans; (3) Trends in achievement of individual outcomes in the Individual Service Plans; (4) Trends in medication and medical incidents leading to adverse health events; (5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels; (6) Quality and completeness documentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**QMB Report of Findings – Optihealth, Inc. – Metro Region – September 23 - 26, 2013**

Survey Report #: Q.14.1.DDW.D1889.5.001.RTN.01.310
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;

(6) Quality and completeness documentation; and

(7) Trends in individual and guardian satisfaction.

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

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

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

(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;

(3)
providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A09</th>
<th>Medication Delivery Routine Medication Administration</th>
<th>Condition of Participation Level Deficiency</th>
<th>Condition of Participation Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<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>Medication Administration Records (MAR) were reviewed for the months of July, August and September 2013.</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</td>
<td>Based on record review, 7 of 9 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
<td>Individual #1 August 2013 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</td>
<td>• Nystop 100,000 Unites/GM (2 times daily) – Blank 8/20 (8:00 PM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Prescribed dosage, frequency and method/route of administration, times</td>
<td>September 2013 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Propranolol 20mg (3 times daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fluticasone 50mcg (1 time daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individual #2 September 2013 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clindamycin HCL 150mg (2 times daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individual #3</td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.14.1.DDW.D1889.5.001.RTN.01.310
and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

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

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

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;

July 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Nystatin 100,000 Units/GM (2 times daily) – Blank 7/25, 27 (8:00 PM)
- Clonidine HCL 0.1mg (2 times daily) – Blank 7/29, 30, 31 (12:00 PM)

August 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Nystatin 100,000 Units/GM (2 times daily) – Blank 8/6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 24, 25, 26, 27, 28, 29, 30, 31 (8:00 PM)
- Clonidine HCL 0.1mg (2 times daily) – Blank 8/5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 20, 22, 23, 27, 28, 30 (12:00 PM)

Individual #4
July 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Chlorpromazine 100mg (1 time daily) – Blank 7/31 (12:00 PM)
- Lorazepam 1mg (2 times daily) – Blank 7/14 (8:00 PM)

Individual #5
July 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Lorazepam 1mg (3 times daily) – Blank 7/1, 2, 3, 8 - 12, 15 - 19, 22 - 26, 29 - 31 (12:00 PM)
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual
D. Administration of Drugs

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

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:
- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

August 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Lorazepam 1mg (3 times daily) – Blank 8/1, 2, 5 - 9, 12 - 16, 19 - 23, 26 – 30 (12:00 PM)

Individual #8
July 2013
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- Fluticasone Prop 50 MCG 1mg (2 times daily) – Blank 7/30 (8:00 AM)

Medication Administration Records did not contain the diagnosis for which the medication is prescribed:
- Olanzapine 2.5mg (1 time daily)
- Fluticasone 50mcg (2 times daily)
- Topamax 50mg (1 time daily)

Medication Administration Records did not contain the route of administration for the following medications:
- Dilantin 100mg (1 time daily)
- Dilantin 150mg (1 time daily)
- Topamax 50mg (1 time daily)

Medication Administration Record did not contain the time the medication should be given. MAR indicated time as “AM and/or PM”:
- Dilantin 100mg (1 time daily)
<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2013</td>
<td>Dilantin 150mg (1 time daily)</td>
<td>Medication Administration Records did not contain the diagnosis for which it is prescribed:</td>
</tr>
<tr>
<td></td>
<td>Topamax 50mg (1 time daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluticasone 50mcg (2 times daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Olanzapine 2.5mg (1 time daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Olanzapine 5mg (1 time daily)</td>
<td></td>
</tr>
<tr>
<td>September 2013</td>
<td>Fluticasone 50mcg (2 times daily)</td>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
</tr>
<tr>
<td></td>
<td>Olanzapine 5mg (1 time daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Olanzapine 2.5mg (1 time daily)</td>
<td></td>
</tr>
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**Individual #10**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2013</td>
<td>Gabapentin 300mg (1 time daily)</td>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td></td>
<td>Clindamycin PH 1% (2 times daily)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fluticasone 50mcg (2 times daily)</td>
<td></td>
</tr>
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</table>
Survey Report #: Q.14.1-DDM-DDM-6588.5.001.RTN.01-3.10

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorazepam 0.5mg</td>
<td></td>
<td>3 times daily</td>
<td>7/31</td>
<td>12:00 PM</td>
</tr>
<tr>
<td>Risperidone 1mg</td>
<td></td>
<td>2 times daily</td>
<td>8/21</td>
<td>8:00 AM</td>
</tr>
<tr>
<td>Lorazepam 0.5mg</td>
<td></td>
<td></td>
<td>8/30</td>
<td>8:00 AM</td>
</tr>
<tr>
<td>Ferrous Gluconate 324mg</td>
<td></td>
<td>1 time daily</td>
<td>8/12, 29</td>
<td>8:00 AM</td>
</tr>
<tr>
<td>Gabapentin 300mg</td>
<td></td>
<td>1 time daily</td>
<td>9/21, 22</td>
<td>8:00 PM</td>
</tr>
<tr>
<td>Clindamycin PH 1%</td>
<td></td>
<td>2 times daily</td>
<td>9/21, 22</td>
<td>8:00 PM</td>
</tr>
<tr>
<td>Lorazepam 0.5mg</td>
<td></td>
<td></td>
<td>8/21, 29</td>
<td>8:00 PM</td>
</tr>
<tr>
<td>Gabapentin 300mg</td>
<td></td>
<td></td>
<td>9/21, 22</td>
<td>8:00 PM</td>
</tr>
<tr>
<td>Clindamycin PH 1%</td>
<td></td>
<td></td>
<td>9/21, 22</td>
<td>8:00 PM</td>
</tr>
</tbody>
</table>

**Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:**

- Lorazepam 0.5mg (3 times daily) – Blank 7/31 (12:00 PM)
- Risperidone 1mg (2 times daily) – Blank 8/21 (8:00 AM)
- Lorazepam 0.5mg (3 times daily) – Blank 8/30 (8:00 AM)
- Clindamycin PH 1% (2 times daily) – Blank 8/21 (8:00 AM)
- Lorazepam 0.5mg (3 times daily) – Blank 8/21, 29 (8:00 AM)
- Gabapentin 300mg (1 times daily) – Blank 9/21, 22 (8:00 PM)
- Clindamycin PH 1% (2 times daily) – Blank 9/21, 22 (8:00 PM)
<table>
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<tr>
<th>Tag # 1A09.1</th>
<th>Medication Delivery PRN Medication Administration</th>
<th>Standard Level Deficiency</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>CHAPTER I 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. <strong>E. Medication Delivery:</strong> Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.</td>
<td><strong>Medication Administration Records (MAR) were reviewed for the months of July, August, and September 2013. Based on record review, 6 of 9 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:</strong> Individual #2 August 2013 Medication Administration Records did not contain the strength of the medication which is to be given: • Wal-Tussin CF Dextromethorphan (PRN) Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Wal-Tussin CF Dextromethorphan (PRN) Individual #4 July 2013 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Lorazepam 1mg – PRN – 7/4, 9 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam 1mg – PRN – 7/4, 9 (given 1 time) Medication Administration Records contain the following medications. No Physician’s Orders were found for the following</td>
<td><strong>Provide:</strong> State your Plan of Correction for the deficiencies cited in this tag here: → <strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
</tbody>
</table>
and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

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

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

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

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

Medications:
• Lorazepam 1mg (PRN)

Medication Administration Records did not contain the exact amount to be used in a 24 hour period:
• Lorazepam 1mg (PRN)

August 2013
No evidence of documented Signs/Symptoms were found for the following PRN medication:
• Lorazepam 2mg – PRN – 8/4, 8, 11, 16, 17, 18, 27 (given 1 time)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
• Lorazepam 2mg – PRN – 8/4, 8, 11, 16, 17, 18, 27 (given 1 time)

Individual #5
July 2013
Medication Administration Records did not contain the circumstance for which the medication is to be used:
• Albuterol 0.083% (PRN)
• Pro Air HFA 90mcg (PRN)

August 2013
Medication Administration Records did not contain the circumstance for which the medication is to be used:
• Albuterol 0.083% (PRN)
• Pro Air HFA 90mcg (PRN)

September 2013
Medication Administration Records did not contain the circumstance for which the
This documentation shall include:
(i) Name of resident;
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual
D. Administration of Drugs

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

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:
- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Department of Health
Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006
F. PRN Medication

3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to:

- Albuterol 0.083% (PRN)

- Pro Air HFA 90mcg (PRN)

Individual #6
August 2013
No evidence of documented Signs/Symptoms were found for the following PRN medication:
- Quetiapine Fumarate 100mg – PRN – 8/20 (given 1 time)

No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- Quetiapine Fumarate 100mg – PRN – 8/20 (given 1 time)

Individual #8
July 2013
No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- Ibuprofen 600mg – PRN – 7/8, 9, 10, 12, 14, 15, 16, 29 (given 1 time)

Medication Administration Records did not contain the circumstance for which the medication is to be used:
- Ibuprofen 600mg (PRN)

August 2013
Medication Administration Records did not contain the circumstance for which the medication is to be used:
- Ibuprofen 600mg (PRN)

September 2013
Medication Administration Records did not contain the circumstance for which the
describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.

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

H. Agency Nurse Monitoring

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual’s response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse’s assessment of the individual and consideration of the individual’s diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual’s condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the medication is to be used:
   - Ibuprofen 600mg (PRN)

Individual #10
July 2013
No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- Quetiapine Fumarate 50 mg – PRN –7/25, 30 (given 1 time)

August 2013
No Effectiveness was noted on the Medication Administration Record for the following PRN medication:
- Acetaminophen 500 mg – PRN –8/10, 12, 23 (given 1 time)
- Quetiapine Fumarate 50 mg – PRN –8/2, 6, 9, 13, 28, 30 (given 1 time)

Medication Administration Records did not contain the circumstance for which the medication is to be used:
- Ibuprofen 200mg (PRN)
individual’s response to medication.

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

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

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

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and 5I09 Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 9 individuals</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td></td>
</tr>
<tr>
<td>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</td>
<td>• Special Health Care Needs:</td>
<td></td>
</tr>
<tr>
<td>(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:</td>
<td>● Meal Time Plan</td>
<td></td>
</tr>
<tr>
<td>(i) Community living services provider agency;</td>
<td>◦ Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.</td>
<td></td>
</tr>
<tr>
<td>(ii) Private duty nursing provider agency;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Adult habilitation provider agency;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) Community access provider agency; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(v) Supported employment provider agency.</td>
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<td></td>
</tr>
<tr>
<td>(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</td>
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<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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</table>

Provider: Enter ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
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,
method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

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

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

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

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

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

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

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

(4) General Nursing Documentation

(a) The nurse shall complete legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served as well as all interactions with other healthcare providers serving the individual. All interactions shall be documented whether they occur by phone or in person.

(b) For individuals with a HAT score of 4, 5 or 6, or who have identified health concerns in their ISP, the nurse shall provide the interdisciplinary team with a quarterly report that indicates current health status and progress to date on health related ISP desired outcomes and action plans as well as progress toward goals in the healthcare plan.


CHAPTER 5 IV. COMMUNITY INCLUSION

SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and

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

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
<table>
<thead>
<tr>
<th>Tag # 1A27</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident Mgt. Late and Failure to Report</td>
<td>Based on the Incident Management Bureau’s Late and Failure Reports, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 5 of 22 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A. Duty To Report:</strong></td>
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<tr>
<td>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</td>
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<tr>
<td>(2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</td>
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<td>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</td>
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<tr>
<td>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</td>
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<tr>
<td>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</td>
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<tr>
<td><strong>B. Notification:</strong> (1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and</td>
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<tr>
<td>Incident report was received 9/20/2012. IMB issued a Late Reporting for Law Enforcement Involvement.</td>
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<tr>
<td>Incident date 8/28/2012. Allegation was Law Enforcement Involvement. Incident report was received 9/20/2012. IMB issued a Late Reporting for Law Enforcement Involvement.</td>
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<tr>
<td>Incident date 4/16/2013. Allegation was Exploitation. Incident report was received 4/22/2013. Failure to Report. IMB Late and Failure Report indicated incident of Exploitation was “Confirmed.”</td>
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<tr>
<td>Incident date 9/17/2012. Allegation was Neglect. Incident report was received 9/18/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Confirmed.”</td>
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<tr>
<td>Incident date 11/7/2012. Allegation was Neglect Environmental Hazard. Incident report was received 11/8/2012. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”</td>
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<td></td>
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<tr>
<td>Incident date 9/17/2011. Allegation was</td>
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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.

Neglect. Incident report was received 9/14/2012. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”

- Incident date 1/20/2012. Allegation was Neglect. Incident report was received 9/14/2012. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was “Unconfirmed.”
<table>
<thead>
<tr>
<th>Tag # 1A28</th>
<th>Incident Mgt. System - Policy/Procedure</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: A. Duty To Report:</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
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<tr>
<td>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</td>
<td>Based on interviews, the Agency did not maintain an incident management system, which emphasizes the principles of prevention and staff involvement as described by regulation</td>
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<tr>
<td>(2) All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</td>
<td>During the on-site survey visits and interviews, the following was found:</td>
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<td>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</td>
<td>During survey it was reported to Surveyors by [name redacted] “They (Optihealth) [sic] are really good at retaliating and suspending staff that report. I have health and safety concerns about one of the houses.” When surveyor's asked what the specific concern was, [name redacted] would not provide additional information as they were concerned of retaliation. Interviewee asked to be kept anonymous due to this fear. As a result their name was removed and health and safety visits were conducted to a majority of the residences. No specific concerns were identified by the survey team.</td>
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<tr>
<td>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</td>
<td>In addition #131 was asked during the administrative interview about incident management and training as well as informed of the anonymous report. #131 explained the importance of reporting and was quite surprised that anyone within the agency would feel this way as she strives to make personnel comfortable in reporting.</td>
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<tr>
<td>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</td>
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<tr>
<td>B. Notification:</td>
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<tr>
<td>(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written correspondence or other forms of communication utilizing the division’s incident report form. The incident</td>
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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 (1-800-797-3260).

(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.

**C. Incident Policies:** All community based service providers shall maintain policies and procedures, which describe the community based service provider’s immediate response to all reported allegations of incidents involving abuse, neglect, or misappropriation of property; all unexpected deaths or natural/expected deaths, and other reportable incidents required as required in Paragraph (2) of Subsection A of 7.1.13.9 NMAC.

**D. Retaliation:** Any individual who, without false intent, reports an incident or makes an allegation of abuse, neglect or exploitation will be free of any form of retaliation.

**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.

**B. Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers’ property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider’s facility. Training shall be conducted in a language that is understood by the employee and volunteer.

**C. Incident Management System Training Curriculum Requirements:**

1. The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable
representative to conduct training, in accordance with the written training curriculum that includes but is not limited to:

(a) an overview of the potential risk of abuse, neglect, misappropriation of consumers' property;
(b) informational procedures for properly filing the division's incident management report form;
(c) specific instructions of the employees’ legal responsibility to report an incident of abuse, neglect and misappropriation of consumers’ property.
(d) specific instructions on how to respond to abuse, neglect, misappropriation of consumers’ property;
(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers’ property; and
(f) where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.
<table>
<thead>
<tr>
<th>Tag # 1A31</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Rights/Human Rights</td>
<td>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
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<tr>
<td></td>
<td>Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 5 of 9 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval and/or that restrictions are being reviewed at least quarterly by the Human Rights Committee for the following: • Door Alarms - (Individual #3, 6) • Inaccessible Door Locks - (Individual #3, 6) • Physical Restraint (MANDT) - (Individual #1, 3, 9) • Locked Sharps - (Individual #1, 3, 6, 9) • Monitoring of Phone Calls - (Individual #1, 9) • Psychotropic Medications to control behaviors. No evidence found of a current quarterly Human Rights Committee approval. (Individual #1, 4)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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Provider:

Long Term Services Division
Policy Title: Human Rights Committee
III. POLICY STATEMENT - Human Rights

Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

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

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

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

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

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each
Department of Health Developmental Disabilities Supports Division (DDSD) -
Procedure Title:
Medication Assessment and Delivery
Procedure Eff Date: November 1, 2006
B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Tag # 6L13</th>
<th>Community Living Healthcare Reqts.</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 9 individuals receiving Community Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING G. Health Care Requirements for Community Living Services.</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
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<td>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual’s health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.</td>
<td>• <strong>Annual Physical</strong> (#3, 8)</td>
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<td>(2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual’s HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role.</td>
<td>• <strong>Dental Exam</strong></td>
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<td>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards</td>
<td>• <strong>Vision Exam</strong></td>
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<td>◦ Individual #8 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</td>
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<td>◦ Individual #4 - As indicated by collateral documentation reviewed, exam was scheduled for 11/8/2012. No evidence of exam results were found.</td>
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<tr>
<td></td>
<td>◦ Individual #8 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
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<td></td>
<td>◦ Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</td>
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Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →

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

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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).
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 # 6L25</th>
<th>Residential Health and Safety (SL/FL)</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 observation, the Agency did not ensure that each individual’s residence met all requirements within the standard for 4 of 7 Supported Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</td>
<td></td>
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<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td>Supported Living Requirements:</td>
<td></td>
</tr>
<tr>
<td>L. Residence Requirements for Family Living Services and Supported Living Services</td>
<td>• Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (2, 4)</td>
<td></td>
</tr>
<tr>
<td>(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:</td>
<td>• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (3, 6, 10)</td>
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<tr>
<td>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</td>
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<td>(b) General-purpose first aid kit;</td>
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<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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<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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<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>
<tr>
<td>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The following Individuals share a residence:  
- #3, 6  

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.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| **Service Domain: Medicaid Billing/Reimbursement** – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. | **Tag # 5I44** Approved**

**Adult Habilitation Reimbursement**


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

A. **General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.

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

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

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

8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:

Providers must maintain all records necessary to fully disclose the extent of the services

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 4 of 7 individuals.</td>
<td></td>
</tr>
</tbody>
</table>

**Individual #1**

July 2013

- The Agency billed 24 units of Adult Habilitation (T2021 U1) on 7/5/2013. Documentation did not contain the required elements on 7/5/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - No documentation found.

- The Agency billed 72 units of Adult Habilitation (T2021 U1) from 7/29/2013 through 7/30/2013. Documentation received accounted for 48 units.

**Individual #4**

June 2013

- The Agency billed 120 units of Adult Habilitation (T2021 U1) from 6/10/2013 through 6/14/2013. Documentation received accounted for 88 units.

- The Agency billed 24 units of Adult Habilitation (T2021 U1) on 7/5/2013. Documentation did not contain the required elements on 7/5/2013. Documentation received accounted for 0 units. One or more of the following elements was not met: | |

**Provider:**

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

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

---


Survey Report #: Q.14.1.DDW.D1889.5.001.RTN.01.310
provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


CHAPTER 5 XVI. REIMBURSEMENT

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

B. Billable Activities

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

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

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

Individual #5

July 2013

- The Agency billed 120 units of Adult Habilitation (T2021 U1) on 7/5/2013. Documentation did not contain the required elements on 7/5/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - A description of what occurred during the encounter or service interval

Individual #10

June 2013

- The Agency billed 120 units of Adult Habilitation (T2021 U1) from 6/3/2013 through 6/7/2013. Documentation received accounted for 48 units.

- The Agency billed 120 units of Adult Habilitation (T2021 U1) from 6/10/2013 through 6/14/2013. Documentation received accounted for 48 units.

- The Agency billed 120 units of Adult Habilitation (T2021 U1) from 6/17/2013 through 6/21/2013. Documentation received accounted for 72 units.

- The Agency billed 120 units of Adult Habilitation (T2021 U1) from 6/24/2013 through 6/28/2013. Documentation received accounted for 72 units.

July 2013

- The Agency billed 24 units of Adult Habilitation (T2021 U1) on 7/6/2013. Documentation did not contain the required...
elements on 7/6/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.

- The Agency billed 28 units of Adult Habilitation (T2021 U1) on 7/9/2013. Documentation received accounted for 24 units.

- The Agency billed 24 units of Adult Habilitation (T2021 U1) on 7/13/2013. Documentation did not contain the required elements on 7/13/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.

- The Agency billed 18 units of Adult Habilitation (T2021 U1) on 7/20/2013. Documentation did not contain the required elements on 7/20/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.

- The Agency billed 16 units of Adult Habilitation (T2021 U1) on 7/27/2013. Documentation did not contain the required elements on 7/27/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.
Date: November 27, 2013

To: Chitra Roy, Executive Director
Provider: Optihealth, Inc.
Address: 4620 Jefferson Lane NE, Suite A
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: croy@optihealthnm.com

Region: Metro
Survey Date: September 23-26, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)
Survey Type: Routine (Expanded)

Re: Request for an Informal Reconsideration of Findings

Dear Mrs. Roy,

Your request for a Reconsideration of Findings was received on November 21, 2013. 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 Documentation Request Form, the Speech Therapy Plan for Individual #1 was requested from and signed by Alaina Dupree on 09/23/13. A final copy of the document request form, still listing the Speech Therapy Plan as missing, was also provided to and signed by Chitra Roy on 09/26/13. Although, documentation provided during the IRF process states the individual has not received SLP Services since December 2012, Speech Therapy remains listed as a service in the Individual's ISP and no documentation was provided to surveyors while on-site to refute the finding. The remaining citations noted in this tag were not disputed.

Regarding Tag # 1A28
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. The determination level for this Tag will be change from a Condition of Participation to a Standard Level Finding. Based on the documentation supplied, your staff are provided training that indicates they are able to report incidents of abuse, neglect and exploitation without fear of retaliation. However, this finding was based on staff perception of the practices at your agency.
Regarding Tag # 1A28.1
Determination: The IRF committee is upholding the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the Training Documentation Request Form, staff training for Service Coordinators #129 and 130 on Incident Management had expired. Verification of these trainings was requested from and signed by Alaina Dupree on 09/25/13. A final copy of the document request form, still listing these trainings as expired, was also provided to and signed by Chitra Roy on 09/26/13. Documentation was not received prior to the end of survey. The remaining citation noted in this tag was not disputed.

Regarding Tag # 1A26
Determination: The IRF committee is removing the original findings in the report of findings. Evidence provided indicated the Employee Abuse Registry check was completed prior to hire for Direct Support Personnel (DSP) #62 and 100. However, please note verification these checks were completed within the required timeframe were requested and not received prior to the end of survey.

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. The modifications and removal of billing deficiencies are as follows:

- Individual #1
  - Billing deficiency for 07/05/2013 will be removed as evidence of a void and adjust form being submitted prior to the QMB on-site survey was provided.

- Individual #10
  - Billing deficiency for 07/06/2013 will be upheld.
    - The agency billed 24 units of Adult Habilitation (T2021 U1) on 07/06/2013. Documentation provided account for 0 units. Documentation did not include:
      - A description of what occurred during the encounter or service interval.
      - The signature or authenticated name of staff providing the service.
  - Billing deficiency for 07/09/2013 will be removed.
  - Billing deficiency for 07/13/2013 will be upheld.
    - The agency billed 24 units of Adult Habilitation (T2021 U1) on 07/13/2013. Documentation provided account for 0 units. Documentation did not include:
      - A description of what occurred during the encounter or service interval.
  - Billing deficiency for 07/20/2013 will be upheld.
    - The agency billed 18 units of Adult Habilitation (T2021 U1) on 07/20/2013. Documentation provided account for 0 units. Documentation did not include:
      - A description of what occurred during the encounter or service interval.
  - Billing deficiency for 07/27/2013 will be upheld.
    - The agency billed 16 units of Adult Habilitation (T2021 U1) on 07/21/2013. Documentation provided account for 0 units. Documentation did not include:
      - A description of what occurred during the encounter or service interval.
      - The signature or authenticated name of staff providing the service.
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,

[Signature]

Crystal Lopez-Beck
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair
Date: January 17, 2014

To: Chitra Roy, Executive Director
Provider: Optihealth, Inc.
Address: 4620 Jefferson Lane NE, Suite A
State/Zip: Albuquerque, New Mexico 87109

E-mail Address: croy@optihealthnm.com

Region: Metro
Survey Date: September 23 - 26, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)
Survey Type: Routine (Expanded)

Dear Ms. Roy;

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.

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

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

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

Sincerely,

Crystal Lopez-Beck
Deputy Bureau Chief
Quality Management Bureau/DHI

Q.14.3.DDW.D1889.5.001.RTN.09.017