Dear Ms. Anderson;

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

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

**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,

*Amanda Castañeda, MPA*

Amanda Castañeda, MPA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: May 28, 2013
Present:

**R-Way, LLC**
Barbara Anderson, Executive Director
John Acuña, Service Coordinator

**DOH/DHI/QMB**
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor
Maria Chavez, BSW, Healthcare Surveyor
Cynthia Nielsen, MSN, RN, Healthcare Surveyor

Exit Conference Date: May 31, 2013
Present:

**R-Way, LLC**
Barbara Anderson, Executive Director
Eloy Montoya, Nurse
Gloria Webb, Service Coordinator
Brenda Solzano, Service Coordinator
John Acuña, Service Coordinator

**DOH/DHI/QMB**
Amanda Castañeda, MPA, Team Lead/Healthcare Surveyor
Nadine Romero, LBSW, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor
Mari Chavez, BSW, Healthcare Surveyor

**DDSD - NE Regional Office**
Fabian Lopez, Social Community Coordinator
Angela Pacheco, Social Community Coordinator

Administrative Locations Visited
Number: 2 - 3205 Richards Lane, Suite B Santa Fe, NM 87507
and 312 Dee Bibb Industrial Dr. Las Vegas, NM 87701

Total Sample Size
Number: 15
0 – Jackson Class Members
15 - Non-Jackson Class Members
12 - Family Living
3 - Independent Living
5 - Community Access

Total Homes Visited
Number: 11
❖ Family Living Homes Visited
Number: 11 (One family was out of town during the on-site survey)

Persons Served Records Reviewed
Number: 15

Persons Served Interviewed
Number: 14

Persons Served Observed
Number: 1 (One Individual was out of town during the on-site survey and was unable to be interviewed or visited)

Direct Support Personnel Interviewed
Number: 17
Direct Support Personnel Records Reviewed  Number: 101

Substitute Care/Respite Personnel Records Reviewed  Number: 18

Service Coordinator Records Reviewed  Number: 5

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
DOH – Internal Review Committee
Attachment A

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

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

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

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

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

Initial Submission of the Plan of Correction Requirements
1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of
Correction Form and received by QMB within ten (10) business days from the date you received the
report of findings.
2. For questions about the POC process, call the QMB POC Coordinator, Crystal Lopez-Beck at 505-
699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD
Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
   a. Electronically at Crystal.Lopez-Beck@state.nm.us (preferred method)
   b. Fax to 505-222-8661, or
   c. Mail to POC Coordinator, 5301 Central Avenue 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 “approve” or “denied.”

Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

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

**POC Document Submission Requirements**

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

1. Your internal documents are due within a **maximum** of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail (paper hard copy or on a disc), fax, or electronically (scanned and attached to e-mails).
3. All submitted documents **must be annotated**; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
   a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
   b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

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


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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.
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 IRC process, email the IRF Chairperson, Scott Good at scott.good@state.nm.us for assistance.

The following limitations apply to the IRF process:
- The 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.
**Agency:** R-Way, LLC - Northeast Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Community Living Supports (Family Living, Independent Living) and Community Inclusion Supports (Community Access)  
**Monitoring Type:** Routine Survey  
**Survey Date:** May 28 – June 3, 2013

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

**Service Domain: Service Plans: ISP Implementation** – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.

**Tag # 1A08 Agency Case File**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 4 of 15 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
</tbody>
</table>

- **Current Emergency and Personal Identification Information**
  - Did not contain Pharmacy Information (###10)
  - Did not contain Health Plan Information (###10)

- **Positive Behavioral Crisis Plan (###5, 12)**
- **Physical Therapy Plan (###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: →


Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
names and telephone numbers of relatives, or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;

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

(3) Progress notes and other service delivery documentation;

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

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

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

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

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

(a) Complete file for the past 12 months;

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

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

(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1 Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 15 Individuals. Review of the Agency individual case files revealed the following items were not found:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>
| Family Living Progress Notes/Daily Contact Logs  
- Individual #8 - None found for 2/28/2013. | |
| Community Access Progress Notes/Daily Contact Logs  
- Individual #10 - None found for 3/16/2013. | |

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

**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;
Tag # 1A32 and 6L14
Individual Service Plan Implementation

<table>
<thead>
<tr>
<th>Condition of Participation Level</th>
<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 12 of 15 individuals. Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
</tr>
<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td></td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Administrative Files Reviewed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
</tr>
<tr>
<td>Individual #2</td>
</tr>
<tr>
<td>• None found regarding: “I will lose 20 lbs within the next year” for 2/2013 – 4/2013.</td>
</tr>
<tr>
<td>Individual #3</td>
</tr>
<tr>
<td>• None found regarding: “Will get the grocery cart and prepare to shop” for 4/2013.</td>
</tr>
<tr>
<td>• None found regarding: “Will put his groceries away at home” for 2/2013 - 4/2013.</td>
</tr>
<tr>
<td>Individual #5</td>
</tr>
<tr>
<td>• None found regarding: “Set up a payment plan to… with rent to hold for trip” for 4/2013.</td>
</tr>
<tr>
<td>• None found regarding: “To prepare a low</td>
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</tbody>
</table>
play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.

[05/03/94; 01/15/97; Recompiled 10/31/01]

cholesterol meal 2x week to lose 20 lbs in a year” for 2/2013 – 4/2013.

Individual #6
- Per Live Outcome; Action Step for “I will prepare a meal” is to be completed 1 time per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2013 – 4/2013.

Individual #7
- “Will participate in different exercises of her choice” is to be completed 3 times per week.” Action Step was not being completed at the required frequency for 11/2012 – 1/2013 and 3/2013 – 4/2013.

- Per Work/learn Outcome; Action Step for “I will correctly count change” is to be completed 3 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2013 – 3/2013.

- “Will work on puzzles with assistance is to be completed 2 times per week.” Action Step was not being completed at the required frequency for 9/2012, 11/2012 - 1/2013 and 3/2013.

Individual #8
- None found regarding: “I will learn safety skills such as stranger safety, fire safety, and water temperature safety” for 2/2013 - 4/2013.

- None found regarding: “I will plan a vacation” for 2/2013 and 4/2013.
<table>
<thead>
<tr>
<th>Individual #10</th>
<th>Per Live Outcome; Action Steps for “I will increase my memory skills” is to be completed 2 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 2/2013 - 4/2013.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual #11</td>
<td>None found for 2/2013 - 4/2013.</td>
</tr>
<tr>
<td>Individual #13</td>
<td>None found for 2/2013 - 4/2013.</td>
</tr>
</tbody>
</table>

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

- **Individual #9**
  - None found regarding: “I will make two deposits a month in my savings account” for 2/2013 – 4/2013.

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

- **Individual #5**
  - None found regarding: “To have a volunteer job” for 2/2013 – 4/2013.

- **Individual #6**
  - None found regarding: “I will volunteer at a place of my choice one time a week” for 2/2013 - 4/2013.

- **Individual #10**
  - None found regarding: “Complete required tasks” for 4/2013.

**Residential Files Reviewed:**

**Family Living Data Collection/Data**
<table>
<thead>
<tr>
<th>Individual #2</th>
<th>None found regarding: I will obtain employment within 18 months for 5/1 – 29, 2013.</th>
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</thead>
<tbody>
<tr>
<td>Individual #4</td>
<td>Per Live Outcome; Action Step for “Will make dinner twice a month is to be completed one time per week” evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/1 – 28, 2013.</td>
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<tr>
<td>Individual #5</td>
<td>None found regarding: “To prepare a low cholesterol meal two times per week to lose 20 pounds in a year” for 5/1 – 29, 2013.</td>
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<td>None found regarding: “To take a trip out of NM” for 5/1 – 29, 2013.</td>
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<tr>
<td>Individual #6</td>
<td>None found regarding: “Will prepare a meal one time per week” for 5/1 – 30, 2013.</td>
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<td>None found regarding: “Will have no documented aspiration pneumonia during my ISP year” for 5/1 – 30, 2013.</td>
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<td></td>
<td>None found regarding: “I will learn four new apps on my iPad to increase my communication skills by practicing three times a week for 30 minutes each time” for 5/1 – 30, 2013.</td>
</tr>
</tbody>
</table>
| Individual #8 | None found regarding: “I will plan a
Individual #10
- Per Live Outcome; Actions Step for “I will increase my memory skills” is to be completed two times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/1 – 30, 2013.

Individual #13
- None found regarding: “To complete chores 50% of the time” for 5/1 – 29, 2013.

Individual #14
- Per Live Outcome; Actions Step for “I will prepare a simple meal in the microwave”, is to be completed 1 time per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/1 – 30, 2013.
  - None found regarding: I will increase my exercise for 5/1 – 30, 2013.
Tag # 6L04
Community Living Scope of Service


CHAPTER 6. II. SCOPE OF COMMUNITY LIVING SERVICES.

A. The scope of Community Living Services includes, but is not limited to the following as identified by the IDT:

1. Assist with money management, including financial record keeping;
2. Assistance to attain and maintain safe and sanitary living conditions that may include general housekeeping, shopping, washing and drying laundry;
3. Assistance to maintain activities of daily living such as bathing, eating, meal preparation, dressing, and individual hygiene;
4. Assistance with mobility and orientation in community integration, access and utilization of natural supports;
5. Assistance in developing and maintaining social, spiritual and individual relationships, to include the development of generic and natural supports of his or her choosing;
6. Assistance to access recreational and leisure activities;
7. Assistance in access to training and educational opportunities on self-advocacy and sexuality;
8. Implementation of the ISP Therapy, Meal-time, Positive Behavioral Supports, Health Care, and Crisis Prevention/Interventions Plans, if applicable;
9. Assistance in developing health maintenance supports, as well as monitoring the effectiveness of such supports;
10. Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and therapy appointments;

When Individual #5 was asked about his environment and his immediate needs, the following was reported:
- Individual #5 indicated he does not get enough money to purchase cleaning supplies or items for his home as well as, his inability to go out on weekends or evening, as he has no staff during those periods.

When DSP #50 was asked by Surveyors if they had copies of medical visits to healthcare practitioners in the home which
maintenance supports, as well as monitoring the effectiveness of such supports;

(10) Provide or arrange for transportation for, but not limited to, Community Inclusion, leisure and recreation activities, medical, dental, and therapy appointments;

(11) Assistance in medication management and pharmacy needs in accordance with the DDSD’s Medication Assessment and Delivery Policy;

(12) Assist the individual as needed, in coordination with the designated healthcare coordinator and others on the IDT, with access to medical, dental, therapy, nutritional, behavioral and nursing practitioners and in the timely implementation of healthcare orders, monitoring and recording of therapeutic plans or activities as prescribed, to include: health care and crisis prevention/intervention plans;

(13) Support individuals to participate in the development of house rules, schedules and planned activities; and

(14) For individuals with a HAT score of 5 or 6, the agency nurse shall participate in the annual ISP meeting and any other IDT meetings called to address a change in health condition/new diagnosis. Such participation will preferably occur in person or by phone, but if that is not possible, may occur via provision of information to the team prior to the meeting with follow up contact afterwards.

are required by standards the following was reported:
- DSP #50 reported that she does not attend medical appointments as the Agency Nurse accompanies the Individual.
<table>
<thead>
<tr>
<th>Tag # 6L14</th>
<th>Residential Case File</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 a complete and confidential case file in the residence for 10 of 12 Individuals receiving Family 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. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
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</tbody>
</table>
| 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: | - **Current Emergency and Personal Identification Information**
  - Did not contain Pharmacy Information (#3, 11)
- Positive Behavioral Plan (#5)
- Positive Behavioral Crisis Plan (#2)
- Speech Therapy Plan (#4, 6, 14)
- Occupational Therapy Plan (#14)
- Physical Therapy Plan (#6)
- **Special Health Care Needs**
  - Nutritional Plan (#14)
- **Health Care Plans**
  - Constipation (#11)
  - Seizures (#4, 13)
- **Medical Emergency Response Plans**
  - Seizures (#4, 13)
- **Progress Notes/Daily Contacts Logs:**
  - Individual #5 - None found for 5/1 – 29, 2013. | Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| (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 | | |


Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
(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

| Individual #6 - None found for 5/1 – 29, 2013. |
| Individual #8 - None found for 5/27 - 28, 2013. |
| Individual #10 – No Time in/Time out or Signatures for 5/1 – 3, 2013. |
| Individual #14 - None found for 5/29/2013. |

- **Record of visits of healthcare practitioners (#5)**
copy must be placed in the agency file on a weekly basis.
(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and
(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
### 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 Transportation Training</th>
<th>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 34 of 101 Direct Support Personnel. No documented evidence was found of the following required training:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here:</td>
<td>→</td>
</tr>
<tr>
<td>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards…</td>
<td>• Transportation (DSP #44, 51, 55, 70, 71, 74, 79, 81, 87, 89, 91, 92, 99, 101, 102, 103, 105, 109, 110, 112, 117, 122, 123, 124, 125, 126)</td>
<td></td>
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<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</td>
<td>When DSP were asked if they had received transportation training including training on wheelchair tie downs and van lift safety the following was reported:</td>
<td></td>
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<tr>
<td>II. POLICY STATEMENTS:</td>
<td>• DSP #46 stated, “No.”</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
<td>→</td>
</tr>
<tr>
<td>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:</td>
<td>• DSP #48 stated, “No.”</td>
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<td>2. Proper lifting procedures</td>
<td>• DSP #54 stated, “No.”</td>
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<td>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver’s seat)</td>
<td>• DSP #66 stated, “No.”</td>
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<tr>
<td>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines</td>
<td>• DSP #77 stated, “No.”</td>
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<td>• DSP #83 stated, “No.”</td>
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</tbody>
</table>
| for supporting       | • DSP #105 stated, "No."
| individuals who may  | • DSP #118 stated, “Not particularly, but they checked my car.”
| 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) |                                                                 |
**Tag # 1A20**  
Direct Support Personnel Training

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>
| Based on record review, the Agency did not ensure Orientation and Training requirements were met for 44 of 101 Direct Support Personnel.  
Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:  
- Pre- Service (DSP #46, 120, 125)  
- Foundation for Health and Wellness (DSP #125)  
- Person-Centered Planning (1-Day) (DSP #84, 125)  
- First Aid (DSP #44, 45, 52, 62, 63, 69, 71, 74, 76, 77, 80, 84, 88, 94, 109, 116, 118, 119, 122, 123, 125, 126)  
- CPR (DSP #44, 45, 51, 62, 63, 69, 71, 74, 76, 84, 94, 109, 116, 118, 119, 122, 125)  
- Assisting With Medication Delivery (DSP #44, 47, 52, 55, 56, 61, 65, 74, 76, 80, 84, 88, 91, 101, 102, 103, 107, 119, 122, 123, 124, 125)  
- Participatory Communication and Choice Making (DSP #62, 80, 90, 101, 124, 126)  
- Rights and Advocacy (DSP #58, 80, 103, 104, 126)  
- Positive Behavior Supports Strategies (DSP #58, 60, 80, 90, 101, 117) |

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

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

---

**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff.**
### March 1, 2007 - II. POLICY STATEMENTS:

<table>
<thead>
<tr>
<th>A.</th>
<th>Individuals shall receive services from competent and qualified staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
</tr>
<tr>
<td>C.</td>
<td>Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</td>
</tr>
<tr>
<td>D.</td>
<td>Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.</td>
</tr>
<tr>
<td>E.</td>
<td>Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.</td>
</tr>
<tr>
<td>F.</td>
<td>Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.</td>
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<tr>
<td>G.</td>
<td>Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.</td>
</tr>
<tr>
<td>H.</td>
<td>Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.</td>
</tr>
<tr>
<td>I.</td>
<td>Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.</td>
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</tbody>
</table>

- Teaching and Support Strategies (DSP #59, 60, 75, 80, 88, 90, 101, 103, 117, 124)
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Agency Personnel Competency</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 interview, the Agency did not ensure training competencies were met for 9 of 17 Direct Support Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</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 the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:</strong></td>
<td><strong>Provider:</strong></td>
<td></td>
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<td></td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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<tr>
<td><strong>F. Qualifications for Direct Service Personnel:</strong> The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency:</td>
<td><em>DSP #50 stated, “I can’t tell you what they are working on. They just started 2 weeks ago with her.”</em> According to the Individual Specific Training Section of the ISP the Individual requires a Positive Behavioral Supports Plan. (Individual #5)</td>
<td></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 an Occupational Therapy Plan and if so, what the plan covered, the following was reported:</strong></td>
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<td>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;</td>
<td><em>DSP #66 stated, “Yes, I’m not sure what they do.”</em> 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>(3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual;</td>
<td><strong>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</strong></td>
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(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

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

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

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

Assessment Tool, the Individual requires Health Care Plans for Body Mass Index
(Individual #5)

- DSP #53 stated, “Salt intake, Hypertension, exercise, medications, and Urinary Retention.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Constipation Management. (Individual #11)

- DSP #54 stated, “Urinary Retention.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Constipation Management. (Individual #11)

- DSP #118 stated, “Seizures.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index and Respiratory. (Individual #14)

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

- DSP #118 stated, “Seizures, that’s the most crisis focal thing.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Respiratory. (Individual #14)

When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:

- DSP #48 stated, "Make sure he has food in
### 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.

- **his system and give him a pill with water.** Per the agency’s Policy Number SS:1.22, “A separate PRN Medication Administration Record Form is to be used for medications that are not given routinely.” DSP did not follow the Agency’s policy. Additionally as indicated by DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP (Individual #5)

- **DSP #92 stated, “No, I don’t document it, it’s just part of what we do for her.** Per the agency’s Policy Number SS:1.22, “A separate PRN Medication Administration Record Form is to be used for medications that are not given routinely.” DSP did not follow the Agency’s policy. (Individual #6)

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

- **DSP #48 stated, “Write on MARS the error and contact the Nurse.”** Per the agency’s Policy Number SS:1.21, “when DSP realize that an error has occurred, complete the Medication Error Report Form immediately.” DSP did not follow the Agency’s policy. (Individual #5)

- **DSP #77 stated, “Throw it away and get another one.”** Per the agency’s Policy Number SS:1.21, “when DSP realize that an error has occurred, complete the Medication Error Report Form immediately.” DSP did not
follow the Agency's policy. (Individual #8)

- DSP #118 stated, “Get rid of that because its contaminated. Dispose properly through Pharmacy.” Per the agency’s Policy Number SS.1.21, “when DSP realize that an error has occurred, complete the Medication Error Report Form immediately.” DSP did not follow the Agency’s policy. (Individual #14)

When DSP were asked what the individual's Diagnosis were, the following was reported:

- DSP #48 stated, “I can’t tell you.” According to the individual's ISP he is diagnosed with High Cholesterol, Sleep Apnea, Edema, and Depression. Staff did not discuss the listed diagnoses. (Individual #5)
<table>
<thead>
<tr>
<th>Tag #1A25</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Caregiver History Screening</td>
<td>Based on record review, the Agency did not maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 2 of 124 Agency Personnel.</td>
</tr>
</tbody>
</table>

The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:

- **Direct Support Personnel (DSP):**
  - #74 – Date of hire 4/4/2012.
  - #125 – Date of hire 8/14/2012.

<table>
<thead>
<tr>
<th>Provider:</th>
<th>State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

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Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
other related felony sexual offenses;

**E.** crimes involving adult abuse, neglect or financial exploitation;

**F.** crimes involving child abuse or neglect;

**G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or

**H.** an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
<table>
<thead>
<tr>
<th>Tag # 1A26</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated On-line Registry Employee Abuse Registry</td>
<td>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 12 of 124 Agency Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. <strong>Provider requirement to inquire of registry.</strong> 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. <strong>Prohibited employment.</strong> 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. <strong>Documentation of inquiry to registry.</strong> 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Support Personnel (DSP):</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>• #57 – Date of hire 10/29/2010.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #74 – Date of hire 4/4/2012.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #125 – Date of hire 8/14/2012.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Support Personnel (DSP):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #42 – Date of hire 7/14/2011, completed 6/3/2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #59 – Date of hire 6/24/2011, completed 1/11/2012.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• #60 – Date of hire 8/17/2011, completed 8/26/2011.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Support Personnel (DSP):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

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

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

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

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

**D. Criminal History Screening:** All personnel shall be screened by the Provider Agency in regard to the employee’s qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and

| #75         | Date of hire 9/2/2011, completed 3/23/2012. |
| #82         | Date of hire 11/13/2009, completed 1/18/2013. |
| #92         | Date of hire 6/14/2011, unable to verify date as no date was found on COR document. |
| #101        | Date of hire 5/10/2011, unable to verify date as no date was found on COR document. |
| #110        | Date of hire 2/7/2011, unable to verify date as no date was found on COR document. |
Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.
<table>
<thead>
<tr>
<th>Tag # 1 A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th></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 23 of 106 Agency Personnel.</td>
<td></td>
</tr>
</tbody>
</table>
| **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. | **Direct Support Personnel (DSP):**  
- Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP# 45, 46, 49, 53, 55, 63, 66, 71, 90, 100, 119, 120, 122, 123, 124, 125, 126)  |
| **D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee’s employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative’s request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. | **Service Coordination Personnel (SC):**  
- Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (SC #142, 143)  |
| **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007**  
**II. POLICY STATEMENTS:**  
A. Individuals shall receive services from | **When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:**  
- DSP #54 stated, “I thought I would just call R-Way.” Staff was not able to identify the two State Agencies as Adult Protective Services and Division of Health Improvement.  
- DSP #77 stated, “New Mexico State and R-Way.” Staff was not able to identify the two State Agencies as Adult Protective Services and Division of Health Improvement.  |
| **When DSP were asked to give examples of Abuse, Neglect and Misappropriation of Consumers' Property, the following was reported:**  
- DSP #54 stated, “I thought I would just call R-Way.” Staff was not able to identify the two State Agencies as Adult Protective Services and Division of Health Improvement.  
- DSP #77 stated, “New Mexico State and R-Way.” Staff was not able to identify the two State Agencies as Adult Protective Services and Division of Health Improvement. | **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:  →  |
|  |  |  |
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

- DSP #48 was unable to provide an example for Exploitation and stated, "I can't think of an example."
- DSP #50 was unable to provide an example for Exploitation and stated, "I don't know."
<table>
<thead>
<tr>
<th>Tag # 1A37</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Specific Training</strong></td>
<td><strong>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 35 of 106 Agency Personnel.</strong>&lt;br&gt;Review of personnel records found no evidence of the following:&lt;br&gt;&lt;br&gt;<strong>Direct Support Personnel (DSP):</strong>&lt;br&gt;- Individual Specific Training (DSP #44, 46, 52, 55, 57, 59, 60, 61, 64, 65, 69, 71, 73, 74, 81, 86, 87, 89, 92, 93, 96, 99, 101, 108, 109, 112, 116, 117, 120, 121, 122, 123, 124, 125, 126)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

**Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
**Standard of Care**

**Deficiencies**

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

**Date Due**

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

<table>
<thead>
<tr>
<th>Tag #</th>
<th>1A03</th>
<th>CQI System</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 had not fully implemented their Continuous Quality Management System as required by standard.</td>
<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 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;</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

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


Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;
(6) Quality and completeness documentation; and
(7) Trends in individual and guardian satisfaction.

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

(1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
(2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
(4) community based service providers providing developmental disabilities
services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
<table>
<thead>
<tr>
<th>Tag # 1A06</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
</table>
| Policy and Procedure Requirements | Based on interview, the Agency did not ensure Agency Personnel were aware of the Agency’s On-Call Policy and Procedures for 1 of 101 Agency Personnel. When DSP were asked if the agency had an on-call procedure, the following was reported:  
  - DSP #53 stated, “I call my daughter.”  
  (Individual #11) | 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: →  |

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

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

1. Coordination of Provider Agency staff serving individuals within the program which delineates the specific roles of agency staff, including expectations for coordination with interdisciplinary team members who do not work for the provider agency;

2. Response to individual emergency medical situations, including staff training for emergency response and on-call systems as indicated; and

3. Agency protocols for disaster planning and emergency preparedness.
<table>
<thead>
<tr>
<th>Tag # 1A09</th>
<th>Medication Delivery Routine Medication Administration</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<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>Medication Administration Records (MAR) were reviewed for the months of March, April and May 2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
<td>Based on record review, 7 of 15 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;</td>
<td>Individual #2 March 2013 Medication Administration Records did not contain the strength of the medication which is to be given:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</td>
<td>• Calcium with Magnesium (1 time daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>April 2013 Medication Administration Records did not contain the strength of the medication which is to be given:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Calcium with Magnesium (1 time daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>May 2013 Medication Administration Records did not contain the diagnosis for which the medication is prescribed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multivitamin (1 time daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Calcium with Magnesium (1 time daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #3 May 2013 Medication Administration Records did not</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

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

### NMAC 16.19.11.8 MINIMUM STANDARDS:

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

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

- (i) Name of resident;
- (ii) Date given;

<table>
<thead>
<tr>
<th>Medication</th>
<th>Frequency</th>
<th>Expected Desired Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>50 + Adv+multivitamin Advanced formula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dilantin Phenytoin 100mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NMAC 16.19.11.8 MINIMUM STANDARDS:**

- Medication Administration Records did not contain the frequency of medication to be given:
  - 50 + Adv+multivitamin Advanced formula

- Medication Administration Record document did not contain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose for the following medications:
  - 50 + Adv+multivitamin Advanced formula
  - Dilantin Phenytoin 100mg

**Individual #4**
May 2013

As indicated by the Medication Administration Records the individual is to take Levothyroxine 25mcg (1 time daily). According to the label on bottle, Levothyroxine 25mg is to be taken 1 time daily. Medication Administration Record and bottle label do not match.

**Individual #5**
May 2013

Medication Administration Records did not contain the route of administration for the following medications:

- Azithromycin 250mg (1 time daily)
- Fluoxetine 20mg (1 time daily)
- Fluoxetine 10mg (1 time daily)
(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.

- Furosemide 20mg (1 time daily)
- Furosemide 40mg (1 time daily)

**Individual #7**

May 2013

During home visit on 5/29/2013, as Surveyors reviewed the MAR’s Surveyor observed that the MARS for Vitamin D and Multivitamin were initialed through 5/31/2013. When Surveyor reviewed the Residential Case File Tool with DSP #134, DSP signed to acknowledge the deficiency.

**Individual #11**

March 2013

As indicated by the Medication Administration Records the individual is to take Hydrochlorothiazide 12.5mg ½ tab (6.25mg) (1 time daily). According to the Physician’s Orders, Hydrochlorothiazide 12.5mg tab is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match.

April 2013

As indicated by the Medication Administration Records the individual is to take Hydrochlorothiazide 12.5mg ½ tab (6.25mg) (1 time daily). According to the Physician’s Orders, Hydrochlorothiazide 12.5mg tab is to be taken 1 time daily. Medication Administration Record and Physician’s Orders do not match.

May 2013

As indicated by the Medication Administration Records the individual is to take Sertraline 50mg (1 time daily). According to the bottle label, Sertraline 100mg is to be taken 1 time daily or as needed Medication Administration.
<table>
<thead>
<tr>
<th>Record and bottle label do not match.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Record did not contain the time the medication should be given. MAR indicated time as “at night”:</td>
</tr>
<tr>
<td>• Avodart .5mg (1time daily)</td>
</tr>
<tr>
<td>Physician’s Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:</td>
</tr>
<tr>
<td>• Fish Oil 1200 mg (1 time daily)</td>
</tr>
<tr>
<td>Individual #14</td>
</tr>
<tr>
<td>March 2013</td>
</tr>
<tr>
<td>Medication Administration Record did not contain the time the medication should be given. MAR indicated time as “AM or PM”:</td>
</tr>
<tr>
<td>• Levothyroxin .75mg (1 time daily)</td>
</tr>
<tr>
<td>• Oxcarbazepine 300mg (3 times daily)</td>
</tr>
<tr>
<td>• Lovastatin 20mg (1 time daily)</td>
</tr>
<tr>
<td>• Vitamin B-12 1000mg (1 time daily)</td>
</tr>
<tr>
<td>• Vitamin D 2000 IU (1 time daily)</td>
</tr>
<tr>
<td>• Zonisamide 100mg (2 times daily)</td>
</tr>
<tr>
<td>• Med Name dosage (X times daily)</td>
</tr>
<tr>
<td>April 2013</td>
</tr>
<tr>
<td>Medication Administration Record did not contain the time the medication should be given. MAR indicated time as “AM or PM”:</td>
</tr>
<tr>
<td>• Levothyroxin .75mg (1 time daily)</td>
</tr>
<tr>
<td>• Oxcarbazepine 300mg (3 times daily)</td>
</tr>
</tbody>
</table>
- Lovastatin 20mg (1 time daily)
- Vitamin B-12 1000mg (1 time daily)
- Vitamin D 2000 IU (1 time daily)
- Zonisamide 100mg (2 times daily)

May 2013
As indicated by the Medication Administration Records the individual is to take Lovastatin 20mg (1 time daily). According to the bottle label, Lovasatin 40mg is to be taken one time daily. Medication Administration Record and bottle label do not match.

As indicated by the Medication Administration Records the individual is to take Vitamin B12 1500mcg (1 time daily). According to the Physician’s Orders, Vitamin B12-Folic Acid 500-400mcg is to be taken one time daily. Medication Administration Record and Physician’s Orders do not match.
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and 5I09</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Documentation</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 15 individuals</td>
</tr>
<tr>
<td></td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td></td>
<td>• Healthcare Passport (#9)</td>
</tr>
<tr>
<td></td>
<td>• Health Care Plans</td>
</tr>
<tr>
<td></td>
<td>• Tube feeding</td>
</tr>
<tr>
<td></td>
<td>Individual #1 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
</tbody>
</table>

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

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

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**Tag # 1A15.2 and 5I09 Healthcare Documentation**


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

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

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

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

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

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

CHAPTER 5 IV. COMMUNITY INCLUSION
SERVICES PROVIDER AGENCY
REQUIREMENTS

B. IDT Coordination

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

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

| Standard Level Deficiency | Provider:  
State your Plan of Correction for the deficiencies cited in this tag here: →  
Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
|---------------------------|---------------------------------------------------------------|
| **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:**  
A. Duty To Report:  
(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.  
(2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:  
(a) an environmental hazardous condition, which creates an immediate threat to life or health; or  
(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.  
(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.  
B. Notification:  
(1) Incident Reporting: Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written |
| Based on record review, the Agency did not report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 15 Individuals.  
During the on-site survey 5/28 – 31, 2013, surveyors observed the following:  
On 5/29/2013 Surveyors conducted an unannounced home visit to the residence of Individual #5. At that time Surveyors entered the FLP’s home and asked to look at the Individual’s bedroom. Surveyors were then directed to a small home in front of the FLP’s home. Surveyors found the condition of the Individual’s residence to be disorganized and unclean. The following was observed in the home:  
- No blinds or curtains where visible in the bedroom and living room windows giving the Individual little to no privacy.  
- There were no smoke detectors in the home. Surveyors asked DSP #48 if the Individual had smoke detectors in the home. DSP#48 reported the Individual had taken them apart and that is why there was none in the home  
- Electrical outlets had no protective covers and were exposed creating a potential environment hazard. |
correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division’s website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.

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

- Two broken light fixtures were found in the living room neither contained light bulbs. One light fixture had a glass housing which was dangling from a mental chain (which had the potential of falling and harming someone). The second light fixture had a broken glass housing which had jagged edges (which had the potential of cutting someone if removed). Each was considered an environmental hazard.

- The Individual had an old small desk which was approximately 1ft x 3ft in size which was also being used as the kitchen table. On the small desk was a calculator and laptop. The two shelves on the right side contained miscellaneous items. The desk allowed little room for the Individual to eat his meals.

- When Surveys asked the Individual if they could look inside the refrigerator, Surveyors found enough grocery to feed the Individual, nevertheless, upon opening the refrigerator door there was a foul odor which smelled of spoiled and/or rotten food. Additionally there were stains and food residue throughout the refrigerator.

- When Surveyors asked the Individual if they could see the Individual’s bedroom, the Individual proceeded to show them his bedroom. Surveyors observed as they entered the bedroom there was a piece of carpet approximately 1ft x 2.5ft which had been placed over broken tile. This was an environmental concern for tripping or cutting one’s foot if barefoot. Also noted were approximately 3 tiles which were cracked and taped down.
When Surveyors asked the FLP (DSP #50) about the condition of the Individual’s home the following was reported:

- DSP #50 indicated the Individual has challenging behaviors which consists of taking apart miscellaneous items and being uncooperative with cleaning.

When Individual #5 was asked about his environment and his immediate needs, the following was reported:

- Individual #5 indicated he does not get enough money to purchase cleaning supplies or items for his home as well as, his inability to go out on weekends or evening, as he has no staff during those periods.

As a result of what was observed the Agency was immediately notified of circumstances and the following incident was reported:

Individual #5
- A State Incident Report of type of Neglect and Environmental Hazard was filed on May 30, 2013.

(Note: NE DDSD office was also informed and an IDT meeting was to be held on the final day of the survey).
<table>
<thead>
<tr>
<th>Tag # 1A28.2</th>
<th>Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.</td>
<td>Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers’ Property, for 1 of 15 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>E. Consumer and Guardian Orientation Packet: Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer’s file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation.</td>
<td>• Parent/Guardian Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (#9)</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td>Tag # 1A33.1</td>
<td>Standard Level Deficiency</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Board of Pharmacy - License | New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual 6. Display of License and Inspection Reports A. The following are required to be publicly displayed: □ Current Custodial Drug Permit from the NM Board of Pharmacy □ Current registration from the consultant pharmacist □ Current NM Board of Pharmacy Inspection Report | Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 1 of 12 residences: Individual Residence: • Current Custodial Drug Permit from the NM Board of Pharmacy (#2) 

Note: Individual #2 shares a residence with an individual who is not on the sample. |

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>Tag # 6L06</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 all DDSD requirements for approval of each direct support provider for 1 of 12 individuals.</td>
</tr>
<tr>
<td>CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES</td>
<td>Review of the Agency files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>A. Support to Individuals in Family Living:</td>
<td>• Monthly Consultation with the Direct Support Provider</td>
</tr>
<tr>
<td>The Family Living Services Provider Agency shall provide and document:</td>
<td>o Individual #1 - None found for 12/2012.</td>
</tr>
<tr>
<td>(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:</td>
<td>Provider:</td>
</tr>
<tr>
<td>(a) Review, advise, and prompt the implementation of the individual’s ISP Action Plans, schedule of activities and appointments; and</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>(b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members.</td>
<td>Provider:</td>
</tr>
<tr>
<td>B. Home Studies. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

Developmental Disabilities (DD) Waiver

Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
CHAPTER 1. PROVIDER AGENCY ENROLLMENT PROCESS

D. Scope of DDSD Agreement

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

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

ELIGIBLE PROVIDERS:

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

(1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.
### Tag # 6L13  
**Community Living Healthcare Reqts.**

**Standard Level Deficiency**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</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 5 of 12 individuals receiving Community Living Services.</td>
</tr>
<tr>
<td>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
</tbody>
</table>
| G. Health Care Requirements for Community Living Services. | - **Dental Exam**  
  - Individual #9 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.  
  - Individual #10 - As indicated by collateral documentation reviewed, exam was completed on 9/10/2012. Follow-up was to be completed on 9/27/2012. No evidence of follow-up found. |
| | - **Vision Exam**  
  - Individual #7 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.  
  - Individual #11 - As indicated by collateral documentation reviewed, exam was completed on 12/8/2011. Follow-up was to be completed in 12 months. No evidence of follow-up found. |
| | - **Urinalysis**  
  - Individual #2 - As indicated by collateral documentation reviewed, exam was ordered on 7/27/2012. No evidence of exam results were found. |

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

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
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>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
</table>
| Residential Health and Safety (SL/FL) | Based on observation, the Agency did not ensure that each individual’s residence met all requirements within the standard for 6 of 12 Family Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Family Living Requirements:**  
• Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#5)  
• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#8)  
• 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 (#5, 8, 14)  
• Accessible telephone numbers of poison control centers located within the line of sight of the telephone (#6, 8, 10)  
• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP (#4, 6, 8, 14)  
• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |

**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**  
**L. Residence Requirements for Family Living Services and Supported Living Services**  
(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:  
(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;  
(b) General-purpose first aid kit;  
(c) When applicable due to an individual’s health status, a blood borne pathogens kit;  
(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;  
(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;  
(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;  
(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and  
(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency
Evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. Placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 14)
<table>
<thead>
<tr>
<th>Tag # 6L25.1</th>
<th>Residential Requirements (Physical Environment – SL/FL)</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sheafter an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td>Based on observation, the Agency did not ensure that each individual’s residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 12 Family Living residences. Family Living Requirements: During on-site visit (5/29/2013), surveyors observed the following: On 5/29/2013 Surveyors conducted an unannounced home visit to the residence of Individual #5. At that time Surveyors entered the FLP’s home and asked to look at the Individual’s bedroom. Surveyors were then directed to a small home in front of the FLP’s home. Surveyors found the condition of the Individual’s residence to be disorganized and unclean. The following was observed in the home:</td>
<td>→ State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>(2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals.</td>
<td>(3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP.</td>
<td>→ Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>(4) Living and Dining Areas shall</td>
<td>(a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests;</td>
<td></td>
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<tr>
<td></td>
<td>(b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and</td>
<td>(c) Provide environmental accommodations based on the unique needs of the individual.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(5) Kitchen area shall:</td>
<td>(a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Arrangements will be made, in consultation with the IDT for environmental accommodations and</td>
<td>(b) Arrangements will be made, in consultation with the IDT for environmental accommodations and</td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211
assistive technology devices specific to the needs of the individual(s); and
(c) Water temperature is required to be maintained at a safe level to both prevent injury and ensure comfort.

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

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

- Electrical outlets had no protective covers and were exposed creating a potential environment hazard.
- Two broken light fixtures were found in the living room neither contained light bulbs. One light fixture had a glass housing which was dangling from a mental chain (which had the potential of falling and harming someone). The second light fixture had a broken glass housing which had jagged edges (which had the potential of cutting someone if removed). Each was considered an environmental hazard.
- The Individual had an old small desk which was approximately 1ft x 3ft in size which was also being used as the kitchen table. On the small desk was a calculator and laptop. The two shelves on the right side contained miscellaneous items. The desk allowed little room for the Individual to eat his meals.
- When Surveys asked the Individual if they could look inside the refrigerator, Surveyors found enough grocery to feed the Individual, nevertheless, upon opening the refrigerator door there was a foul odor which smelled of spoiled and/or rotten food. Additionally there were stains and food residue throughout the refrigerator.
- When Surveyors asked the Individual if they could see the Individual's bedroom, the Individual proceeded to show them his bedroom. Surveyors observed as they entered the bedroom there was a piece of carpet approximately 1ft x 2.5ft which had been placed over broken tile. This was an environmental concern for tripping or cutting...
| one’s foot if barefoot. Also noted were approximately 3 tiles which were cracked and taped down. |
|---|---|---|
| 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 # 5I36** | **Community Access Reimbursement** | **Standard Level Deficiency** |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Community Access Services for 3 of 5 individuals. | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |
| **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** | **Individual #5** April 2013 | **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
| 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. | The Agency billed 29 units of Community Access (H2021, U1) from 4/8/2013 through 4/11/2013. Documentation received accounted for 80 units. |  |
| **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: | Individual #10 March 20013 |  |
| (1) Date, start and end time of each service encounter or other billable service interval; | The Agency billed 30 units of Community Access (H2021, U1) 3/16/2013. Documentation did not contain the required elements on 3/16/2013. Documentation received accounted for 0 units. One or more of the following elements was not met: |  |
| (2) A description of what occurred during the encounter or service interval; and | No documentation found. |  |
| (3) The signature or authenticated name of staff providing the service. | The Agency billed 30 units of Community Access (H2021, U1) on 3/20/2013. Documentation received accounted for 26 units. |  |
| **MAD-MR: 03-59 Eff 1/1/2004** | Individual #11 April 2013 |  |
| **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**Providers must maintain all records necessary to fully disclose the extent of the services | The Agency billed 84 units of Community Access (H2021, U1) from 4/16/2013 through 4/19/2013. Documentation received accounted for 80 units. |  |
provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS

G. Reimbursement

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

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

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

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

(a) Time and expense for training service personnel;
(b) Supervision of agency staff;
(c) Service documentation and billing activities; or
(d) Time the individual spends in segregated facility-based settings activities.
<table>
<thead>
<tr>
<th>Tag # 6L27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Living Reimbursement</td>
</tr>
</tbody>
</table>

### Standard Level Deficiency

Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 7 of 12 individuals.

**Individual #1**  
April 2013  
- The Agency billed 14 units of Family Living (T2033) from 4/11/2013 through 4/24/2013. Documentation did not contain the required elements on 4/11 – 24, 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 #4**  
February 2013  
- The Agency billed 7 units of Family Living (T2033) from 2/14/2013 through 2/20/2013. Documentation did not contain the required elements on 2/16/2013. Documentation received accounted for 6 units. One or more of the following elements was not met:  
  - Documentation found indicated only Substitute Care was provided.

**March 2013**  
- The Agency billed 7 units of Family Living (T2033) from 3/21/2013 through 3/27/2013. Documentation did not contain the required elements on 3/22 – 23, 2013. Documentation received accounted for 5 units. One or more of the following elements was not met:  
  - Documentation found indicated only Substitute Care was provided.

### Provider:

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

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

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Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211

**CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES**

**B. Reimbursement for Family Living Services**

1. **Billable Unit:** The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.

2. **Billable Activities shall include:**
   - (a) Direct support provided to an individual in the residence any portion of the day;
   - (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
   - (c) Any other activities provided in accordance with the Scope of Services.

3. **Non-Billable Activities shall include:**
   - (a) The Family Living Services Provider Agency may not bill the for room and board;
   - (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
   - (c) Family living services may not be billed for the same time period as Respite.
   - (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this purpose a day is counted from one midnight to the following midnight.

---

**April 2013**

- The Agency billed 7 units of Family Living (T2033) from 4/4/2013 through 4/10/2013. Documentation did not contain the required elements on 4/5 – 6, 2013. Documentation received accounted for 5 units. One or more of the following elements was not met:
  - Documentation found indicated only Substitute Care was provided

- The Agency billed 7 units of Family Living (T2033) 4/18/2013 through 4/24/2013. Documentation did not contain the required elements on 4/19 – 20, 2013. Documentation received accounted for 5 units. One or more of the following elements was not met:
  - Documentation found indicated only Substitute Care was provided

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**Individual #5**

**February 2013**

- The Agency billed 6 units of Family Living (T2033) from 2/1/2013 through 2/6/2013. Documentation did not contain the required elements on 2/1 – 6, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 2/7/2013 through 2/13/2013. Documentation did not contain the required
III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

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

DEFINITIONS

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

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

elements on 2/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

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

- The Agency billed 7 units of Family Living (T2033) from 2/14/2013 through 2/20/2013. Documentation did not contain the required elements on 2/14 – 20, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

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

- The Agency billed 7 units of Family Living (T2033) from 2/21/2013 through 2/27/2013. Documentation did not contain the required elements on 2/21 – 27, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval;
- A description of what occurred during the encounter or service interval; and
- The signature or authenticated name of staff providing the service.
• The Agency billed 1 unit of Family Living (T2033) on 2/28/2013. Documentation did not contain the required elements on 2/28/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.

March 2013
• The Agency billed 6 units of Family Living (T2033) from 3/1/2013 through 3/6/2013. Documentation did not contain the required elements on 3/1 – 6, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.

• The Agency billed 7 units of Family Living (T2033) from 3/7/2013 through 3/13/2013. Documentation did not contain the required elements on 3/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.
The Agency billed 7 units of Family Living (T2033) from 3/14/2013 through 3/20/2013. Documentation did not contain the required elements on 3/14 – 20, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
- A description of what occurred during the encounter or service interval; and
- The signature or authenticated name of staff providing the service.

The Agency billed 7 units of Family Living (T2033) from 3/21/2013 through 3/27/2013. Documentation did not contain the required elements on 3/21 – 27, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
- A description of what occurred during the encounter or service interval; and
- The signature or authenticated name of staff providing the service.

The Agency billed 4 units of Family Living (T2033) from 3/28/2013 through 3/31/2013. Documentation did not contain the required elements on 3/28 – 31, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
interval;
- A description of what occurred during the encounter or service interval; and
- The signature or authenticated name of staff providing the service.

April 2013
- The Agency billed 3 units of Family Living (T2033) from 4/1/2013 through 4/3/2013. Documentation did not contain the required elements on 4/1 – 3, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 4/4/2013 through 4/10/2013. Documentation did not contain the required elements on 4/4 – 10, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 4/11/2013 through 4/17/2013. Documentation did not contain the required elements on 4/11 – 17, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- The Agency billed 7 units of Family Living (T2033) from 4/18/2013 through 4/24/2013. Documentation did not contain the required elements on 4/18 – 24, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - A description of what occurred during the encounter or service interval; and
  - The signature or authenticated name of staff providing the service.

Individual #6
February 2013
- The Agency billed 6 units of Family Living (T2033) from 2/1/2013 through 2/6/2013. Documentation did not contain the required elements on 2/1 – 6, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 2/7/2013 through 2/13/2013. Documentation did not contain the required elements.
elements on 2/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 2/14/2013 through 2/20/2013. Documentation did not contain the required elements on 2/14 – 20, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 2/21/2013 through 2/27/2013. Documentation did not contain the required elements on 2/21 – 27, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 1 unit of Family Living (T2033) on 2/28/2013. Documentation did not contain the required elements on 2/28/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
March 2013

- The Agency billed 6 units of Family Living (T2033) from 3/1/2013 through 3/6/2013. Documentation did not contain the required elements on 3/1 – 6, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 3/7/2013 through 3/13/2013. Documentation did not contain the required elements on 3/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 3/7/2013 through 3/13/2013. Documentation did not contain the required elements on 3/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.
The Agency billed 7 units of Family Living (T2033) from 3/14/2013 through 3/20/2013. Documentation did not contain the required elements on 3/14 – 20, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service.

The Agency billed 7 units of Family Living (T2033) from 3/21/2013 through 3/27/2013. Documentation did not contain the required elements on 3/21 – 27, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service.

The Agency billed 4 units of Family Living (T2033) from 3/28/2013 through 3/31/2013. Documentation did not contain the required elements on 3/28 – 31, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service.
April 2013

- The Agency billed 3 units of Family Living (T2033) from 4/1/2013 through 4/3/2013. Documentation did not contain the required elements on 4/1 – 3, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 4/4/2013 through 4/10/2013. Documentation did not contain the required elements on 4/4 – 10, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living (T2033) from 4/11/2013 through 4/17/2013. Documentation did not contain the required elements on 4/11 – 17, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service.

- The Agency billed 7 units of Family Living
(T2033) from 4/18/2013 through 4/24/2013. Documentation did not contain the required elements on 4/18 – 24, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service.

Individual #7
February 2013
- The Agency billed 6 units of Family Living (T2033) from 2/1/2013 through 2/6/2013. Documentation did not contain the required elements on 2/5 – 6, 2013. Documentation received accounted for 4 units. One or more of the following elements was not met:
  - Documentation found indicated only Substitute Care was provided

March 2013
- The Agency billed 7 units of Family Living (T2033) from 3/14/2013 through 3/20/2013. Documentation did not contain the required elements on 3/16 – 17, 2013. Documentation received accounted for 5 units. One or more of the following elements was not met:
  - Documentation found indicated only Substitute Care was provided

April 2013
- The Agency billed 7 units of Family Living (T2033) from 4/4/2013 through 4/10/2013. Documentation did not contain the required elements on 4/8 – 9, 2013. Documentation received accounted for 5 units. One or more of the following elements was not met:
 Documentation found indicated only Substitute Care was provided

Individual #8
February 2013
• The Agency billed 1 unit of Family Living (T2033) on 2/28/2013. Documentation did not contain the required elements on 2/28/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ No documentation found.

Individual #10
February 2013
• The Agency billed 6 units of Family Living (T2033) from 2/1/2013 through 2/6/2013. Documentation did not contain the required elements on 2/1 – 6, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Date, start and end time of each service encounter or other billable service interval;
  ➢ The signature or authenticated name of staff providing the service. Contained only initials

• The Agency billed 7 units of Family Living (T2033) from 2/7/2013 through 2/13/2013. Documentation did not contain the required elements on 2/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Date, start and end time of each service encounter or other billable service interval;
  ➢ The signature or authenticated name of staff providing the service. Note: Documentation contained only initials of
The Agency billed 7 units of Family Living (T2033) from 2/14/2013 through 2/20/2013. Documentation did not contain the required elements on 2/14 – 20, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service. Note: Documentation contained only initials of staff.

The Agency billed 7 units of Family Living (T2033) from 2/21/2013 through 2/27/2013. Documentation did not contain the required elements on 2/21 – 27, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service. Note: Documentation contained only initials of staff.

The Agency billed 1 unit of Family Living (T2033) on 2/28/2013. Documentation did not contain the required elements on 2/28/2013. Documentation received accounted for 0 units. One or more of the following elements was not met:

- Date, start and end time of each service encounter or other billable service
The signature or authenticated name of staff providing the service. **Note:** Documentation contained only initials of staff.

March 2013
- The Agency billed 6 units of Family Living (T2033) from 3/1/2013 through 3/6/2013. Documentation did not contain the required elements on 3/1 – 6, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service. **Note:** Documentation contained only initials of staff.

- The Agency billed 7 units of Family Living (T2033) from 3/7/2013 through 3/13/2013. Documentation did not contain the required elements on 3/7 – 13, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service. **Note:** Documentation contained only initials of staff.

Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service. *Note: Documentation contained only initials of staff.*

- The Agency billed 7 units of Family Living (T2033) from 3/21/2013 through 3/27/2013. Documentation did not contain the required elements on 3/21 – 27, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service. *Note: Documentation contained only initials of staff.*

- The Agency billed 4 units of Family Living (T2033) from 3/28/2013 through 3/31/2013. Documentation did not contain the required elements on 3/28 – 31, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  - Date, start and end time of each service encounter or other billable service interval;
  - The signature or authenticated name of staff providing the service. *Note: Documentation contained only initials of staff.*
April 2013
• The Agency billed 3 units of Family Living (T2033) from 4/1/2013 through 4/3/2013. Documentation did not contain the required elements on 4/1 – 3, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Date, start and end time of each service encounter or other billable service interval;
  ➢ The signature or authenticated name of staff providing the service. Note: Documentation contained only initials of staff.

• The Agency billed 7 units of Family Living (T2033) from 4/4/2013 through 4/10/2013. Documentation did not contain the required elements on 4/4 – 10, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Date, start and end time of each service encounter or other billable service interval;
  ➢ The signature or authenticated name of staff providing the service. Note: Documentation contained only initials of staff.

• The Agency billed 7 units of Family Living (T2033) from 4/11/2013 through 4/17/2013. Documentation did not contain the required elements on 4/11 – 17, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
  ➢ Date, start and end time of each service encounter or other billable service interval;
  ➢ The signature or authenticated name of staff providing the service.
The Agency billed 7 units of Family Living (T2033) from 4/18/2013 through 4/24/2013. Documentation did not contain the required elements on 4/18 – 24, 2013. Documentation received accounted for 0 units. One or more of the following elements was not met:
- Date, start and end time of each service encounter or other billable service interval;
- The signature or authenticated name of staff providing the service. Note: Documentation contained only initials of staff.
<table>
<thead>
<tr>
<th>Tag # 6L28</th>
<th>Independent Living Reimbursement</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Independent Living Services for 1 of 3 individuals.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</td>
<td>March 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) A description of what occurred during the encounter or service interval; and</td>
<td>• The Agency billed 1 unit of Independent Living (T2030) from 3/1/2013 through 3/31/2013. Per Individual’s budget the individual is to receive Regular (no less than 20 hours) Independent Living. Documentation received accounted for 11.75 hours, which is less than the required amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
<td>March 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.4.DDW.D4209.2.001.RTN.01.211

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

D. Reimbursement for Independent Living Services: The billable unit for Independent Living Services is a monthly rate with a maximum of 12 units a year. Independent Living Services is reimbursed at two levels based on the number of hours of service needed by the individual as specified in the ISP. An individual receiving at least 20 hours but less than 100 hours of direct service per month will be reimbursed at Level II rate. An individual receiving 100 or more hours of direct service per month will be reimbursed at the Level I rate.
Date: October 25, 2013

To: Barbara Anderson, Executive Director
Provider: R-Way, LLC
Address: 3205 Richards Lane, Suite B
State/Zip: Santa Fe, New Mexico 87507

New Address: 4001 Office Court, Suite 905
Santa Fe, NM 87507

E-mail Address: Barbann1123@aol.com

Region: Northeast
Survey Date: May 28 – June 3, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Family Living, Independent Living) and Community Inclusion Supports (Community Access)
Survey Type: Routine

Dear Ms. Anderson;

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

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

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

After reviewing the documentation submitted through your Plan of Correction, the following items are still outstanding:

- Tag 1A11.1
  - Transportation Training (DSP# 101)
- Tag 1A20
  - First Aid (DSP #76)
  - CPR (DSP #76)
  - AWMD (DSP #76)
  - Participatory Communication and Choice Making (DSP #60, 80, 90, 101)
  - Rights and Advocacy (DSP #58, 80)
  - Positive Behavior Supports Strategies (DSP #58, 80, 90
  - Teaching and Support Strategies (DSP #59, 60, 75, 80, 88, 90, 101, 117, 124)
- Tag 1A28.1
  - Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property) (DSP#90)
- Tag 1A37
Individual Specific Training (DSP #59)

Tag 6L27

Family Living Reimbursement

- Individual #1
  - The agency billed 14 units of Family Living (T2033) from 4/11/2013 through 4/24/2013. Documentation did not support billing on 4/14-04/18/2013 and 4/23/2013. Per progress notes provided, the Individual was with Natural Supports on these dates.

- Individual #4
  - The agency billed 7 units of Family Living (T2033) from 2/11/2013 through 2/20/2013. Documentation did not support billing on 2/16/2013. Per progress notes provided, the Individual was with substitute care on this date.

  - The agency billed 7 units of Family Living (T2033) from 3/21/2013 through 3/27/2013. Documentation did not support billing on 3/22-3/23/2013. Per progress notes provided, the Individual was with substitute care on these dates.

  - The agency billed 7 units of Family Living (T2033) from 4/04/2013 through 4/10/2013. Documentation did not support billing on 4/05-4/06/2013. Per progress notes provided, the Individual was with substitute care on these dates.

  - The agency billed 7 units of Family Living (T2033) from 4/18/2013 through 4/24/2013. Documentation did not support billing on 4/19-4/20/2013. Per progress notes provided, the Individual was with substitute care on these dates.

- Individual #7
  - The agency billed 7 units of Family Living (T2033) from 3/14/2013 through 3/20/2013. Documentation did not support billing on 3/16/2013-3/17/2013. Per progress notes provided, the Individual was with substitute care on this date.

***Please provide verification of submitted void and adjusts forms to correct billing deficiencies immediately. All other items will be reviewed during the Verification Survey.

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

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

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

Sincerely,

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

Q.14.2.DDW.24883310.5&3.001.RTN.07.298