Date: September 11, 2013

To: Mark DuBois, Executive Director

Provider: Supporting Hands, LLC
Address: 2527 Virginia St. NE Suite E
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: supportinghandsnm@msn.com

Region: Metro
Survey Date: August 13 - 15, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)
Survey Type: Routine
Team Leader: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Marti Madrid, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. DuBois;

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,

*Erica Nilsen, BA*

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

Entrance Conference Date: August 13, 2013

Present:

Supporting Hands, LLC
Chad Arnold, Service Coordinator
Angela Gutierrez, Office Manager

DOH/DHI/QMB
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor

Exit Conference Date: August 15, 2013

Present:

Supporting Hands, LLC
Mark DuBois, Executive Director
Chad Arnold, Service Coordinator
Angela Gutierrez, Office Manager

DOH/DHI/QMB
Erica Nilsen, BA, Team Lead/Healthcare Surveyor
Jennifer Bruns, BSW, Healthcare Surveyor

DDSD - Metro Regional Office
Carol Sena, Assistant Metro Regional Manager

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 2 (One Individual was part of the routine survey and the other Individual was a Health and Safety visit only)
1 - Jackson Class Member
1 - Non-Jackson Class Member
1 - Supported Living
1 - Adult Habilitation
1 - Health and Safety visit only

Total Homes Visited
Number: 2

- Supported Living Homes Visited
Number: 2

Persons Served Records Reviewed
Number: 1

Persons Served Interviewed
Number: 2

Direct Support Personnel Interviewed
Number: 3

Direct Support Personnel Records Reviewed
Number: 9

Service Coordinator Records Reviewed
Number: 3 (2 Agency Personnel do not hold official Service Coordinator titles, however, they are on-call personnel who may perform duties in the realm of Service Coordinator and/or Direct Service Personnel)

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:
  o Individual Service Plans
  o Progress on Identified Outcomes
  o Healthcare Plans
  o Medication Administration Records
  o Medical Emergency Response Plans
  o Therapy Evaluations and Plans
  o Healthcare Documentation Regarding Appointments and Required Follow-Up
  o 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.”
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.
The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief within 10 business days of receipt of the final Report of Findings.
2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding form available on the QMB website: http://dhi.health.state.nm.us/qmb
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.
5. If you have questions about the 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.
<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>
<tbody>
<tr>
<td><strong>Service Domain: Service Plans: ISP Implementation</strong> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
<td>Based on record review, the Agency did not complete quarterly reports as required for 1 of 1 individuals receiving Community Inclusion services. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: <strong>Adult Habilitation Quarterly Reports</strong> - Individual #1 - None found for 4/2013 - 6/2013.</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>
(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;
(6) Record of personally meaningful community inclusion;
(7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and
(8) Any additional reporting required by DDSD.
<table>
<thead>
<tr>
<th>Tag # 6L14</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Case File</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 1 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td></td>
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<tr>
<td>(1) Complete and current ISP and all supplemental plans specific to the individual;</td>
<td></td>
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<tr>
<td>(2) Complete and current Health Assessment Tool;</td>
<td></td>
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<tr>
<td>(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;</td>
<td></td>
</tr>
<tr>
<td>(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);</td>
<td></td>
</tr>
<tr>
<td>(5) Data collected to document ISP Action Plan implementation</td>
<td></td>
</tr>
<tr>
<td>(6) Progress notes written by direct care staff</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: →

Provider: →

Provider: →
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 copy must be placed in the agency file on a weekly basis.
(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and

(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
<table>
<thead>
<tr>
<th>Tag # 6L17 Reporting Requirements (Community Living Reports)</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 complete written quarterly status reports for 1 of 1 individuals receiving Community Living Services.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td>Review of the Agency individual case files revealed the following items were not found, and/or incomplete:</td>
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<tr>
<td>D. Community Living Service Provider Agency Reporting Requirements: All Community Living Support providers shall submit written quarterly status reports to the individual’s Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:</td>
<td>Support Living Annual Assessment</td>
<td></td>
</tr>
<tr>
<td>(1) Timely completion of relevant activities from ISP Action Plans</td>
<td>• Individual #1 - None found for 10/13/2011 – 10/12/2012.</td>
<td>Provider:</td>
</tr>
<tr>
<td>(2) Progress towards desired outcomes in the ISP accomplished during the quarter;</td>
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<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
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<td>(3) Significant changes in routine or staffing;</td>
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<td>(4) Unusual or significant life events;</td>
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<td>(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and</td>
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<td>(6) Data reports as determined by IDT members.</td>
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</table>


Survey Report #: Q.14.1.DDW.75129027.5.001.RTN.01.254
**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 # 1A20</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>
**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.  
**C. Orientation and Training Requirements:** Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:  
1. Each new employee shall receive appropriate orientation, including but not limited to, all policies relating to fire prevention, accident prevention, incident management and reporting, and emergency procedures; and  
2. Individual-specific training for each individual under his or her direct care, as |

Based on record review, the Agency did not ensure Orientation and Training requirements were met for 9 of 9 Direct Support Personnel.  

Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:  
- Foundation for Health and Wellness (DSP #12)  
- Person-Centered Planning (1-Day) (DSP #12,16)  
- First Aid (DSP #13, 15, 16,17)  
- CPR (DSP #13, 15, 16,17)  
- Assisting With Medication Delivery (DSP #10, 11, 12, 13, 14, 15, 16, 17,18)  

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

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


Survey Report #: Q.14.1.DDW.75129027.5.001.RTN.01.254

Page 18 of 57
described in the individual service plan, prior to working alone with the individual.

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.
F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.
G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.
H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.
<table>
<thead>
<tr>
<th>Tag # 1A22</th>
<th>Agency Personnel Competency</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on interview, the Agency did not ensure training competencies were met for 2 of 3 Direct Support Personnel.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here:</td>
</tr>
<tr>
<td></td>
<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>When DSP were asked if they had received training on the Individual's Seizures, the following was reported:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:</td>
</tr>
<tr>
<td></td>
<td>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for</td>
<td>• DSP #13 stated, &quot;I have not received training on his seizures.&quot; As indicated by documentation review, the Individual has a diagnosis of seizures. (Individual #1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• DSP #14 stated, “The BT did, but I have never been trained by the nurse.” As indicated by documentation review, the Individual has a diagnosis of seizures. (Individual #1)</td>
<td></td>
</tr>
</tbody>
</table>


Survey Report #: Q.14.1.DDW.75129027.5.001.RTN.01.254
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 - 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.
### Tag # 1A25
**Criminal Caregiver History Screening**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<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 12 Agency Personnel.</td>
</tr>
</tbody>
</table>

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

#### Direct Support Personnel (DSP):

---

**NMAC 7.1.9.8** CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:

**F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.

**NMAC 7.1.9.9** CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:

**A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.

**NMAC 7.1.9.11** DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:

- **A.** homicide;
- **B.** trafficking, or trafficking in controlled substances;
- **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery;
- **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;

---

**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: →
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 # 1A28.1</th>
<th>Incident Mgt. System - Personnel Training</th>
<th>Condition of Participation Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</strong></td>
<td></td>
<td></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>A. General:</strong> All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. <strong>D. Training Documentation:</strong> All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee’s employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative’s request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule. <strong>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</strong></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 ensure Incident Management Training for 9 of 12 Agency Personnel. <strong>Direct Support Personnel (DSP):</strong> • Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (DSP# 10, 11, 13, 14, 17,18) <strong>Service Coordination Personnel (SC):</strong> • Incident Management Training (Abuse, Neglect and Misappropriation of Consumers’ Property) (SC #19, 20, 21)</td>
<td>Provide: Enter your ongoing Quality Assurance/Q... Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>Tag # 1A37</td>
<td>Individual Specific Training</td>
<td>Standard Level Deficiency</td>
<td>Provider:</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 1 of 12 Agency 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>Review of personnel records found no evidence of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Orientation and Training Requirements:</td>
<td>Direct Support Personnel (DSP):</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td>• Individual Specific Training (DSP #15)</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Individuals shall receive services from competent and qualified staff.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.</td>
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</tr>
</tbody>
</table>
**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>Agency Plan of Correction, On-going QA/QI and Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard.</td>
<td>Review of the Agency’s CQI Plan revealed the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 1 PROVIDER AGENCY ENROLLMENT PROCESS</td>
<td>• The Agency’s CQI Plan did not contain the following components:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Continuous Quality Management System: Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</td>
<td>(1) Trends in medication and medical incidents leading to adverse health events;</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</td>
<td></td>
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</tr>
</tbody>
</table>


Survey Report #: Q.14.1.DDW.75129027.5.001.RTN.01.254

Page 27 of 57
(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.
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.

A. General Requirements:

(2) The Provider Agency is required to develop and implement written policies and procedures that maintain and protect the physical and mental health of individuals and which comply with all DDSD policies and procedures and all relevant New Mexico State statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed.

Based on record review and interview, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures.

Review of Agency policies and procedures found the following:

No evidence of the following policies and procedures:

- Nursing on-call Policy and Procedure.

When #21 was asked if the Agency had a Nursing on-call Policy and Procedure and what it covered, the following was reported:

- #21 stated, “The nursing on-call policy, it’s on a server that’s not working. If there’s a problem, let nurse know. She will indicate what to do.”

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 # 1A07</th>
<th>Social Security Income (SSI) Payments</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 and interview, the Agency did not maintain and enforce written policies and procedures regarding the use of individuals’ SSI payments or other personal funds.</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</strong> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Review of the Agency’s policies and procedures found no evidence of a policy regarding individual SSI payments or other personal funds.</td>
<td></td>
</tr>
<tr>
<td>C. Provider Agency Financial Records and Accounting: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual’s SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual.</td>
<td><strong>When #21 was asked if the Agency had policies and procedures regarding the use of individuals’ SSI payments or other personal funds, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Code of Federal Regulations:</strong> §416.635 What are the responsibilities of your representative payee…</td>
<td>• #21 stated, “No, it’s on a share file, and I can’t access it.” #21 indicated the Agency had a policy, but was unable to print it out. The policy could not be verified by Surveyors.</td>
<td></td>
</tr>
<tr>
<td>A representative payee has a responsibility to: (a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines under the guidelines in this subpart, to be in your best interests; (b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
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</tbody>
</table>
she is your spouse or natural or adoptive parent or stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement;
(c) Treat any interest earned on the benefits as your property;
(d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them;
(e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us;
(f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and
§416.640 Use of benefit payments.

Current maintenance. We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items.

§416.665 How does your representative payee account for the use of benefits...
Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except for certain State institutions that participate in a separate onsite review program). We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request.
## Tag # 1A09.1 Medication Delivery PRN Medication Administration

### Standard Level Deficiency

Medication Administration Records (MAR) were reviewed for the months of May, June and August 2013.

Based on record review, 1 of 1 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard:

**Individual #1**  
May 2013  
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:  
- Triazolam 0.25MG (PRN)

As indicated by the Medication Administration Records the individual is to take Acetaminophen 325MG (PRN) 2 tablets by mouth as needed every 4 hours. According to the Physician’s Orders, Acetaminophen 325MG, is not to exceed 8 tablets in a 24-hour period. Medication Administration Record and Physician’s Orders do not match.

June 2013  
Medication Administration Records contain the following medications. No Physician’s Orders were found for the following medications:  
- Triazolam 0.25MG (PRN)

As indicated by the Medication Administration Records the individual is to take Acetaminophen 325MG (PRN) 2 tablets by mouth as needed every 4 hours. According to the Physician’s Orders, Acetaminophen...
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(d)</td>
<td>Explanation of any medication irregularity;</td>
</tr>
<tr>
<td>(e)</td>
<td>Documentation of any allergic reaction or adverse medication effect; and</td>
</tr>
<tr>
<td>(f)</td>
<td>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.</td>
</tr>
<tr>
<td>(3)</td>
<td>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;</td>
</tr>
<tr>
<td>(4)</td>
<td>MARs are not required for individuals participating in Independent Living who self-administer their own medications;</td>
</tr>
<tr>
<td>(5)</td>
<td>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 administrating the medication, signs and symptoms of adverse events and interactions with other medications;</td>
</tr>
</tbody>
</table>

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(d)</td>
<td>The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:</td>
</tr>
<tr>
<td>(i)</td>
<td>Name of resident;</td>
</tr>
<tr>
<td>(ii)</td>
<td>Date given;</td>
</tr>
</tbody>
</table>

325MG, is not to exceed 8 tablets in a 24-hour period. Medication Administration Record and Physician’s Orders do not match.
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual

D. Administration of Drugs

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

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

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

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

F. PRN Medication

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

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

H. Agency Nurse Monitoring
1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual’s response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse’s assessment of the individual and consideration of the individual’s diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual’s condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual’s response to medication.
Medication Assessment and Delivery Procedure Eff Date: November 1, 2006

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

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

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
<table>
<thead>
<tr>
<th>Tag # 1A15.2 and 5I09 Healthcare Documentation</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required per standard for 1 of 1 individual</td>
</tr>
<tr>
<td>CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services.</td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
</tbody>
</table>
| 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 | • Medication Administration Assessment Tool (#1)  
• Aspiration Risk Screening Tool (#1)  
• Special Health Care Needs:  
  • Nutritional Plan  
    ◦ Individual #1 - As indicated by the IST section of ISP, the individual is required to have a plan. No evidence of a plan found.  
  • Medical Emergency Response Plans  
    • Seizures  
      ◦ Individual #1 - According to the Electronic Comprehensive Health Assessment Tool, the individual is required to have a plan. No evidence of a plan 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: →

Provider: →
consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

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

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

(e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active
health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.
(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):
(a) Each healthcare plan must include a statement of the person's healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.
(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.
(c) Approaches described in the plan shall be individualized to reflect the individual's unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.
(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.
(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.
(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.
(g) All crisis prevention and intervention plans and healthcare plans shall include the individual's name and date on each page and shall be signed by the author.
(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

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


CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

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

(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010
F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:
1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>A27.2</th>
<th>Duty to Report</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</td>
<td></td>
<td>Based on record review and interview, 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 1 Individuals.</td>
<td></td>
</tr>
<tr>
<td>A. Duty To Report:</td>
<td></td>
<td>During the on-site survey August 13 - 15, 2013, surveyors observed the following:</td>
<td></td>
</tr>
<tr>
<td>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</td>
<td></td>
<td>During the on-site visit Surveyors reviewed personnel files which indicated DSP #10, 11, 12, 13, 14, 15, 16, 17 and 18 were not current and/or had no record of completing the Assisting with Medication Delivery training and were assisting with medications for Individual #1. During interviews, when DSP #13 and 14 were asked by Surveyor if they assisted with medications, DSP #13 and 14 indicated they currently do assist with medications.</td>
<td></td>
</tr>
<tr>
<td>(2) All community based service providers shall report to the division within twenty four (24) hours: abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; and other reportable incidents to include:</td>
<td></td>
<td>As a result of what was observed the following incident(s) was reported:</td>
<td></td>
</tr>
<tr>
<td>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</td>
<td></td>
<td>Individual #1</td>
<td></td>
</tr>
<tr>
<td>(b) admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider.</td>
<td></td>
<td>• A State Incident Report of Neglect was filed on September 10, 2013.</td>
<td></td>
</tr>
<tr>
<td>(3) All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>B. Notification:</td>
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</tbody>
</table>
correspondence or other forms of communication utilizing the division’s incident report form. The incident report form and instructions for the completion and filing are available at the division's website; http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number.

(2) Division Incident Report Form and Notification by Community Based Service Providers: The community based service provider shall report incidents utilizing the division’s incident report form consistent with the requirements of the division’s incident management system guide. The community based service provider shall ensure all incident report forms alleging abuse, neglect or misappropriation of consumer property submitted by a reporter with direct knowledge of an incident are completed on the division’s incident report form and received by the division within twenty-four (24) hours of an incident or allegation of an incident or the next business day if the incident occurs on a weekend or a holiday. The community based service provider shall ensure that the reporter with the most direct knowledge of the incident prepares the incident report form.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>A28.2</th>
<th>Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
</table>
|       |       | **NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:**  
A. General: All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.  
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. | 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 1 individual.  
Review of the Agency individual case files revealed the following items were not found and/or incomplete:  
- Parent/Guardian Incident Management Training (Abuse, Neglect and Misappropriation of Consumers' Property' (#1) | 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: → |


<table>
<thead>
<tr>
<th>Tag # 1A29</th>
<th>Complaints / Grievances Acknowledgement</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.26.3.6 A</td>
<td>These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</td>
<td>Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 1 of 1 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>NMAC 7.26.3.13 Client Complaint Procedure Available. A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client’s rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client’s rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td>• Grievance/Complaint Procedure Acknowledgement (#1)</td>
<td></td>
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</tr>
<tr>
<td>NMAC 7.26.4.13 Complaint Process: A. (2). The service provider’s complaint or grievance procedure shall provide, at a minimum, that: (a) the client is notified of the service provider’s complaint or grievance procedure</td>
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<td></td>
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<tr>
<td>Tag # 1A31</td>
<td>Client Rights/Human Rights</td>
<td>Condition of Participation Level Deficiency</td>
<td>Provider:</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT’S RIGHTS:</strong></td>
<td></td>
<td></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>A. A service provider shall not restrict or limit a client's rights except:</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td></td>
<td></td>
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<tr>
<td>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</td>
<td>Based on record review and interview, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 1 Individuals.</td>
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<tr>
<td>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</td>
<td>A review of Agency Individual files found no documentation of Positive Behavior Plans or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#1)</td>
<td></td>
<td></td>
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<tr>
<td>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</td>
<td>No documentation was found regarding Human Rights Approval for the following:</td>
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<td></td>
<td>• Physical Restraint (Individual #1)</td>
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<td></td>
<td>• Psychotropic Medications to control behaviors (PRN) (Individual #1)</td>
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<td></td>
<td>• Locked Sharps (Individual #1)</td>
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<tr>
<td></td>
<td>• Plexi-Glass covering windows (Individual #1)</td>
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<td>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review.</td>
<td>When #21 was asked if the Agency had documentation of Human Rights approval, the following was reported,</td>
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<td>The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider’s behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</td>
<td>• #21 stated, “It’s been close to a year since we had a meeting. Can’t get anyone to come to a meeting. We have tried to contact other agencies, doesn’t work”.</td>
<td></td>
</tr>
<tr>
<td>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</td>
<td>In addition to the above mentioned review of the Agency’s Policy and Procedure, it was found it did not address the frequency and purpose of</td>
<td></td>
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</tr>
<tr>
<td><strong>Long Term Services Division</strong></td>
<td><strong>IV. POLICY STATEMENT - Human Rights</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003</strong></td>
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</tr>
</tbody>
</table>

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Survey Report #: Q.14.1.DDW.75129027.5.001.RTN.01.254
Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

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

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

### A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

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

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

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual’s Individual Service Plan.
Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006
B. 1. e. If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
Tag # 6L13  
Community Living Healthcare Reqts. | Standard Level Deficiency
---|---
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 1 of 1 individuals receiving Community Living Services.

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

- **Involuntary Movement Evaluations**
  - None found 6/2012 - 6/2013 for Seroquel (#1)

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

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

Provider:

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.
### Standard of Care

**Service Domain:** *Medicaid Billing/Reimbursement* – State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

### Tag # 5I44

**Adult Habilitation Reimbursement**

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

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

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

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

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

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

**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**

Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 1 of 1 individual. Individual #1</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td><strong>April 2013</strong></td>
<td></td>
</tr>
<tr>
<td>The Agency billed 120 units of Adult Habilitation (T2021 U1, U4) from 4/1/2013 through 4/6/2013. Documentation received accounted for 96 units.</td>
<td></td>
</tr>
<tr>
<td><strong>May 2013</strong></td>
<td></td>
</tr>
<tr>
<td>The Agency billed 120 units of Adult Habilitation (T2021 U1, U4) from 5/13/2013 through 5/19/2013. Documentation received accounted for 96 units. Documentation did not contain the required elements on 5/16. One or more of the following elements was not met:</td>
<td></td>
</tr>
<tr>
<td>➢ A description of what occurred during the encounter or service interval</td>
<td></td>
</tr>
<tr>
<td>The Agency billed 120 units of Adult Habilitation (T2021 U1, U4) from 5/20/2013 through 5/24/2013. Documentation received accounted for 104 units.</td>
<td></td>
</tr>
<tr>
<td><strong>June 2013</strong></td>
<td></td>
</tr>
<tr>
<td>The Agency billed 120 units of Adult Habilitation (T2021 U1, U4) from 6/17/2013 through 6/23/2013. Documentation received accounted for 96 units.</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

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

| | } |
| that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. |


**CHAPTER 5 XVI. REIMBURSEMENT**

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

**B. Billable Activities**

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

2. Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours.
<table>
<thead>
<tr>
<th>Tag # 6L26</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supported Living Reimbursement</strong></td>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 1 of 1 individual.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.

**June 2013**

- The Agency billed 2 units of Supported Living (T2033 U1, U4) from 6/1/2013 through 6/2/2013. Documentation on 6/1 and 6/2 indicated “At parents for weekend.” Documentation did not indicate the time the individual departed or returned. Documentation received accounted for 0 units.

**Provider:**

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

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

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

CHAPTER 6. IX. REIMBURSEMENT FOR
COMMUNITY LIVING SERVICES
A. Reimbursement for Supported Living Services
(1) Billable Unit. The billable Unit for
Supported Living Services is based on a
daily rate. The daily rate cannot exceed
340 billable days a year.

(2) Billable Activities
   (a) Direct care provided to an individual in
       the residence any portion of the day.
   (b) Direct support provided to an individual
       by community living direct service staff
       away from the residence, e.g., in the
       community.
   (c) Any activities in which direct support
       staff provides in accordance with the
       Scope of Services.

(3) Non-Billable Activities
   (a) The Supported Living Services provider
       shall not bill DD Waiver for Room and
       Board.
   (b) Personal care, respite, nutritional
       counseling and nursing supports shall
       not be billed as separate services for an
       individual receiving Supported Living
       Services.
   (c) The provider shall not bill when an
       individual is hospitalized or in an
       institutional care setting.
Date: November 26, 2013

To: Mark DuBois, Executive Director
Provider: Supporting Hands, LLC
Address: 2527 Virginia St. NE Suite E
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: supportinghandsnm@msn.com

Region: Metro
Survey Date: August 13 - 15, 2013
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living) and Community Inclusion Supports (Adult Habilitation)
Survey Type: Routine

Dear Mr. DuBois;

The Division of Health Improvement/Quality Management Bureau completed a Routine Survey of the services your agency provides on August 13-15, 2013. The Plan of Correction process for this survey was scheduled to close November 20, 2013; however, prior to completion of your Plan of Correction your agency closed and all Developmental Disability Waiver (DDW) clients were transitioned to other agencies.

The Plan of Correction process has been closed INCOMPLETE.

A Plan of Correction for the above mentioned survey was never approved and documentation to verify correction of survey deficiencies was not received; however, due to your agency’s closure no further action is required.

Sincerely,

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

Q.14.2.DDW.75129027.5.001.RTN.09.330