Date:	October 26, 2011
To:	Michael Binkley, President
Provider:	Su Vida Services, Inc.
Address:	8501 Candelaria, Bldg. A
State/Zip:	Albuquerque, New Mexico 87112
E-mail Address:	mikebinkley@suvidaservices.com
Region:	Metro, Northeast & Northwest
Survey Date:	August 29 – September 2, 2011
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	Living Supports (Supported Living, Family Living & Independent Living) & Inclusion Supports (Adult Habilitation & Community Access)
Survey Type:	Routine – Process Pilot
Team Leader:	Nadine Romero, LBSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Crystal Lopez-Beck, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management, William Bazinet, BSN, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Cynthia Nielsen, MSN, RN, ONC, CCM, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Jennifer Brown, Community Living Service Coordinator, Developmental Disabilities Supports Division

Dear Mr. Binkley,

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

Determination of Compliance:

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

Compliance with all Conditions of Participation

The attached QMB Report of Findings indicates all identified deficiencies are at the Standard Level and require a Plan of Correction.

Plan of Correction:

The attached Report of Findings identifies the Standard Level deficiencies found during your agency's compliance

review. You are required to complete and implement a Plan of Correction. Your agency has 45 business 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 all remedies must still be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within 10 days or complete and implement your Plan of Correction within the 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 business days. 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 505-222-8647 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,

Nadine Romero, LBSW

Nadine Romero, LBSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	August 29, 2011	
Present:	**Su Vida Services, Inc.** Mike Binkley, President Patsy Rios, Vice President **DOH/DHI/QMB** Nadine Romero, LBSW, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Crystal Lopez-Beck, BS, Healthcare Surveyor Cynthia Nielsen, MSN, RN, ONC, CCM, Clinical Liaison William Bazinet, BSN, RN, Healthcare Surveyor	
Exit Conference Date:	September 1, 2011	
Present:	**Su Vida Services, Inc.** Michael Binkley, President Patsy Rios, Vice President Tippy Watson, Director of Quality Assurance/Treasure Antonio Tapia, Services Coordinator Paola Lima, Day Supports Manager Diana Ottavio, LPN Rhonda O'Brien, Service Coordinator, Vicki Miracle, CFO **DOH/DHI/QMB** Nadine Romero, LBSW Team Lead/Healthcare Surveyor Deb Russell, BS, Healthcare Surveyor Tony Fragua, BFA, Healthcare Surveyor Cynthia Nielsen, MSN, RN, ONC, CCM, Clinical Liaison William Bazinet, BSN, RN, Healthcare Surveyor **DDSD - Metro Regional Office** Jennifer Brown, Community Living Service Coordinator	
Total Homes Visited	Number:	16
❖ Supported Homes Visited	Number:	3
❖ Family Homes Visited	Number:	13
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	22 2 - *Jackson* Class Members 20 - Non-*Jackson* Class Members 3 - Supported Living 14 - Family Living 2 - Independent Living 10 - Adult Habilitation 12 - Community Access
Persons Served Interviewed	Number:	22
Persons Served Records Reviewed	Number:	22
Direct Service Professionals Interviewed	Number:	30
Direct Service Professional Records Reviewed	Number:	162

Service Coordinator Records Reviewed Number: 5

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedure
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Human Rights Notes and/or Meeting Minutes
- Evacuation Drills
- Quality Assurance / Improvement Plan

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

Attachment A

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

Introduction:
After a QMB Compliance Review, 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 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 505-222-8647 or email at George.Perrault@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 business days.
- Direct care issues should be corrected immediately and monitored appropriately.
- Some deficiencies may require a staged plan to accomplish total correction.
- Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
    a. Electronically at George.Perrault@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the POC Coordinator.
6. QMB will notify you when your POC has been “approve” or “denied.”
    a. 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 Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

QMB Determinations of Compliance

- "Compliance with Conditions of Participation"
  The QMB determination of "Compliance with Conditions of Participation," indicates that a provider is in compliance with all 'Conditions of Participation,' (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals' health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.

- "Partial-Compliance with Conditions of Participation"
  The QMB determination of "Partial-Compliance with Conditions of Participation" indicates that a provider is out of compliance with one (1) to three (3) 'Conditions of Participation.' This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

- "Non-Compliant with Conditions of Participation":
  The QMB determination of "Non-Compliance with Conditions of Participation," indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  a. Four (4) Conditions of Participation out of compliance.
  b. Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
  c. Any finding of actual harm or Immediate Jeopardy.

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

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Su Vida Services, Inc. - Metro, Northwest, Northeast Region**
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living, Family Living & Independent Living) & Community Inclusion (Adult Habilitation & Community Access)
Monitoring Type: Routine Survey – Process Pilot
Date of Survey: **August 29 – September 2, 2011**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Qualified Providers – *The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements*			
Tag # 1A22 Staff Competence			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards. **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;	Based on interview, the Agency failed to ensure that training competencies were met for 8 of 30 Direct Service Professionals. **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and what the plan covered, the following was reported:** • DSP #90 stated, "I'm not sure." According to the Individual Specific Training Section of the ISP the individual has Positive Behavioral Crisis Plan. (Individual #17) **When DSP were asked if they received training on the Individual's Speech Therapy Plan and what the plan covered, the following was reported:** • DSP #70 stated, "No." According to the Individual Specific Training Section of the ISP the Individual requires a Speech Therapy Plan. (Individual #12) **When DSP were asked if they received training on the Individual's Physical Therapy Plan and what the plan covered, the following was reported:**	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. _____	

(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 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	• DSP #194 stated "I don't know." According to the Individual Specific Training Section of the ISP the Individual requires a Physical Therapy Plan. (Individual #3) • DSP #90 stated "Not that I know of." According to the Individual Specific Training Section of the ISP the individual requires a Physical Therapy Plan (Individual #17) **When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:** • DSP #101 stated, "I haven't been trained on any HCP that I know of. " As indicated by the Agency file, the Individual has Health Care Plans for TBI, Obesity, High Cholesterol, Healthy Life Style, and falls (Individual #11) • DSP #70 stated, "No. " As indicated by the Agency file, the Individual has Health Care Plans for Aspiration & Cerebral Shunt (Individual #12) • DSP #170 - As indicated by the Agency file, the Individual has Health Care Plans for Skin Breakdown, Incontinence, Oral care, Positioning for feeding. Staff did not discuss the listed HCP (Individual #13) **When DSP were asked if they received training on the Individual's Crisis Plans/Medical Emergency Response Plans and what the plan covered, the following was reported:** • DSP #101 stated, "I haven't been trained on any that I know of." As indicated by the Agency file, the Individual has Crisis Plans/Medical Response Plans for TBI, Obesity, High Cholesterol, Healthy Life Style, and falls (Individual #11) • DSP #170 stated "No" As indicated by the Agency file, the Individual has Crisis		

(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.	Plans/Medical Response Plans Care Plans for Aspiration, Seizures. Staff did not discuss the listed HCP(Individual #13) **When DSP were asked if they had received training regarding the individual's Seizure Disorder, the following was reported:** • DSP #98 stated, "I don't remember getting trained on her seizures through the agency" According to the ISP, the individual has a diagnosis of Seizures. (Individual #10) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #44 - According to the individuals ISP he is diagnosed with Tubular Sclerosis and High Lipids, Staff did not discuss these listed diagnosis. (Individual #1) • DSP #133 - According to the individuals ISP she is diagnosed with Osteoporosis, MR. Allergic Rhinitis, and Menopausal Staff did not discuss these listed diagnosis. (Individual #4) • DSP #170 - According to the individuals ISP he is diagnosed with Quadriplegic, Psoriasis, Scoliosis, Low iron, Contractures. Staff did not discuss these listed diagnoses. (Individual #13)		

Tag # 1A25 CCHS			
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; **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.	Based on record review, the Agency failed to 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 1 of 167 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Service Professional (DSP):** • #153 – Date of Hire 9/25/06	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation.*			
Tag # 1A09 Medication Delivery (MAR) - Routine Medication			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;	Medication Administration Records (MAR) were reviewed for the months of June, July & August 2011. Based on record review, 4 of 17 individuals had Medication Administration Records, which contained missing medications entries and/or other errors for the following: Individual #4 June 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Omeprazole 20 mg (1 time daily) July 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Omeprazole 20 mg (1 time daily) Individual #5 July 2011 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Propranolol 10 mg (2 times daily) Individual #17 June 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Seroquel 200mg – Blank 6/4, 5, 6, 11, 12, 13,	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

(c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration;	18, 19, 20, 25, 26 & 27 (12 PM) • Carbamazepine 200mg – Blank 6/4, 5, 6, 11, 12, 13, 18, 19, 20, 25, 26 & 27 (12 PM) Medication Administration Records did not contain the frequency of medication to be given: • Seroquel 200mg • Carbamazepine 200mg During on-site survey Physician Orders were requested. As of July 28, 2011, Physician Orders had not been provided. July 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Seroquel 200mg – Blank 7/2, 3, 4, 9, 10, 11, 16, 17, 18, 23, 24, 25, 30 & 31 (12 PM) • Carbamazepine – Blank 7/2, 3, 4, 9, 10, 11, 16, 17, 18, 23, 24, 25, 30 & 31 (12 PM) Medication Administration Records did not contain the frequency of medication to be given: • Seroquel 200mg • Carbamazepine 200mg During on-site survey Physician Orders were requested. As of July 28, 2011, Physician Orders had not been provided. Individual #19 June 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonazepam 1mg (3 times daily) – Blank 6/4, 5,		

(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.	6, 8, 9, 12, 13, 15, 18, 19, 21, 22, 23, 24, 26, 27, 28 & 30 (4 PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Folic Acid 1mg (1 time daily) • Potassium Chloride 10% 2 tbsp (2 times daily) July 2011 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Clonazepam 1 mg (3 times daily) – Blank 7/3, 4, 6, 8, 15, 16 & 17 (4 PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Folic Acid 1mg (1 time daily) Potassium Chloride 10% 2 tbsp (2 times daily) During on-site survey Physician Orders were requested. As of July 28, 2011, Physician Orders had not been provided.		

Tag # 1A09.1 Medication Delivery - PRN Medication			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and	Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 1 of 17 Individuals. Individual #9 June 2011 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Claritin 10mg (PRN) • Ibuprofen 600mg (PRN) July 2011 Physician's Orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records: • Claritin 10mg (PRN) • Benadryl 25mg (PRN)	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications; **NMAC 16.19.11.8 MINIMUM STANDARDS:** **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (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. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention.			

(References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).			

Tag # 1A15.2 & 5I09 - Healthcare Documentation			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services:** Nursing services must be available as needed and documented for Provider Agencies delivering Community Living Services, Community Inclusion Services and Private Duty Nursing Services. **Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities** (a) The following hierarchy shall be used to determine which provider agency is responsible for completion of the HAT and MAAT and related subsequent planning and training: (i) Community living services provider agency; (ii) Private duty nursing provider agency; (iii) Adult habilitation provider agency; (iv) Community access provider agency; and (v) Supported employment provider agency. (b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the	Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 3 of 22 individual The following were not found, incomplete and/or not current: • **Special Health Care Needs:** • Nutritional Evaluation ◦ Individual #19 - According to IST the individual is required to have an evaluation. No evidence of evaluation found. • Meal Time Plan ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • Nutritional Plan ◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. Collateral documentation indicated follow-up was to be completed 7/2011. No evidence of follow-up found. • **Health Care Plans** • Seizures ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. • Skin Wound ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan • Bowel and Bladder ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. _____	

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	• **Crisis Plans/Medical Emergency Response Plans** • Seizures ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan • Skin Wound ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan • Bowel and Bladder ◦ Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan		

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

CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS **B. IDT Coordination** (1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.			

Tag # 1A27 Late & Failure to Report			
7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS: **A. Duty To Report:** **(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division. **(2)** All community based service providers shall report to the division within twenty four (24) hours : abuse, neglect, or misappropriation of property**,** unexpected and natural/expected deaths; and other reportable incidents to include: **(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or **(b)** admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care which is unanticipated or unscheduled for the consumer and which would not routinely be provided by a community based service provider. **(3)** All community based service providers shall ensure that the reporter with direct knowledge of an incident has immediate access to the division incident report form to allow the reporter to respond to, report, and document incidents in a timely and accurate manner. **B. Notification**: **(1) Incident Reporting:** Any consumer, employee, family member or legal guardian may report an incident independently or through the community based service provider to the division by telephone call, written 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.	Based on the Incident Management Bureau's Late and Failure Reports, the Agency failed to report suspected abuse, neglect, or misappropriation of property, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 23 individuals. Individual #23 • Incident date 9/20/2010. Allegation was Neglect, Exploitation & Environmental Hazard. Incident report was received 9/21/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

Tag # 1A31 Client Rights/Human Rights			
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior	Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 1 of 22 Individuals. A review of Agency Individual files indicated 1 of 22 Individuals required Human Rights Committee Approval for restrictions. • Psychotropic Medications to control behaviors. No current evidence found of Human Rights Committee approval. (Individual #12)	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms			

in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 6L13 - CL Healthcare Reqts.			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, which ever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6	Based on record review, the Agency failed to provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 5 of 19 individuals receiving Community Living Services. The following were not found, incomplete and/or not current: • **Vision Exam** ◦ Individual #12 - As indicated by collateral documentation reviewed, exam was completed on 9/4/09. Follow-up was to be completed in 1 year. No evidence of follow-up found. • **Auditory Exam** ◦ Individual #14 - As indicated by collateral documentation reviewed, exam was completed on 12/9/10. Follow-up was to be completed in 6 months. No evidence of follow-up found. • **Mammogram Exam** ◦ Individual #8 - As indicated by collateral documentation reviewed, exam was recommended 1/21/11. No evidence of exam results was found. ▪ **Cholesterol & Blood Glucose** ◦ Individual #6 - As indicated by collateral documentation reviewed, lab work was ordered on 11/9/10. No evidence of lab results was found. • **Abnormal Involuntary Movement Screening** ◦ None found 7/2010 – 7/2011 for Reglan (#19)	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

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	Deficiencies	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 Agency Case File			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate; (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT); (3) Progress notes and other service delivery documentation;	Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 22 individuals. Review of the Agency individual case files found the following items were not found, incomplete, and/or not current: • **Positive Behavior Plan** (#3) • **Positive Behavior Crisis Plan** (#11) • **Vision Exam** ◦ Individual #2 - As indicated by collateral documentation reviewed, the exam was completed on 9/4/09. As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of current exam was found. • **Neurology** ◦ Individual #11 - As indicated by collateral documentation reviewed, exam was completed on 11/23/10. Follow-up was to be completed in 6 months. No evidence of follow-up found.	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line. _____	

(4) Crisis Prevention/Intervention Plans, if there are any for the individual; (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request. (8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies: (a) Complete file for the past 12 months; (b) ISP and quarterly reports from the current and prior ISP year; (c) Intake information from original admission to services; and (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital. **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.			

Tag # 6L14 Residential Case File			
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of	Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 7 of 17 Individuals receiving Family Living and Supported Living Services The following was not found, incomplete and/or not current: • **Current Emergency & Personal Identification Information** ° Did not contain Pharmacy Information Telephone number (#1) • Positive Behavioral Plan (#11) • Positive Behavioral Crisis Plan (#11) • Speech Therapy Plan (#13) • **Health Care Plans** ° Oral Hygiene (#9) ° BMI (#9) ° Falls (#20) ° Skin Integrity (#1) • **Medical Emergency Response Plans/Crisis Plans** ° Cardiac Condition (#6) ° Aspiration (#6 & 13) ° Falls (#20) • **Progress Notes/Daily Contacts Logs:** ° Individual #19 - None found for 8/1/2011 – 8/31/2011	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

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.			

Standard of Care	*Deficiencies*	Agency Plan of Correction, On-going QA/QI & Responsible Party	Date Due
CMS Assurance – Financial Accountability – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*.			
Tag # 5I36 CA 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 that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 2 of 12 individuals. Individual #15 May 2011 • The Agency billed 60 units of Community Access (H2021) from 5/1/2011 through 5/31/2011. Documentation received accounted for 47 units. June 2011 • The Agency billed 49 units of Community Access (H2021) from 6/21/2011 through 6/24/2011 on Documentation received accounted for 25 units. Individual #16 July 2011 • The Agency billed 264 units of Community Access (H2021) from 7/1/2011 through 7/31/2011. Documentation received accounted for 256 units.	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS** **G. Reimbursement** (1) Billable Unit**:** A billable unit is defined as one-quarter hour of service. (2) Billable Activities**:** The Community Access Provider Agency can bill for those activities listed in the Community Access Scope of Service. Billable units are typically provided face-to-face but time spent in non face-to-face activity may be claimed under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity, and is tied directly to the individual's ISP, Action Plan; (b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and (c) Non face-to-face hours do not exceed 10% of the monthly billable hours. (3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include: (a) Time and expense for training service personnel; (b) Supervision of agency staff; (c) Service documentation and billing activities; or (d) Time the individual spends in segregated facility-based settings activities.			

Tag # 5I44 AH 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 that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation	Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 10 individuals. Individual #1 July 2011 • The Agency billed 548 units of Adult Habilitation (T2021) from 7/1/2011 through 7/31/2011. Documentation received accounted for 524 units. Individual #4 July 2011 • The Agency billed 192 units of Adult Habilitation (T2021) from 7/1/2011 through 7/31/2011. Documentation received accounted for 182 units. Individual #12 May 2011 • The Agency billed 212 units of Adult Habilitation (T2021) from 5/1/2011 through 5/31/2011. Documentation received accounted for 196 units. Individual #13 July 2011 • The Agency billed 74 units of Adult Habilitation (T2021) from 7/1/2011 through 7/31/2011. Documentation received accounted for 37 units. Individual #17 July 2011 • The Agency billed 304 units of Adult Habilitation (T2021) from 7/1/2011 through 7/31/2011. Documentation received accounted for 286 units.	Provider: In addition to stating the Plan of Correction for these findings above, also please provide your evidence of on-going Quality Assurance / Quality Improvement specific to this tag below this line.	

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			

Date: November 21, 2011

To: Michael Binkley, President
Provider: Su Vida Services, Inc.
Address: 8501 Candelaria NE Building A
State/Zip: Albuquerque, New Mexico 87112

E-mail Address: mikebinkley@suvidaservices.com

Region: Metro, Northeast & Northwest
Survey Date: Aug. 29-Sept. 2, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living & Community Inclusion
Survey Type: Routine

RE: Request for an Informal Reconsideration of Findings

Dear Mr. Binkley,

Your request for a Reconsideration of Findings was received on November 17, 2011. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 5I44
Determination: The IRF committee is removing the original finding in the report. Based on documentation supplied, all deficiencies will be removed.

Regarding Tag # 5I36
Determination: The IRF committee is removing the original finding in the report. Based on documentation supplied, all deficiencies will be removed.

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

Thank you.
Respectfully,

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

CC: File, DHI, DDSD

Date: December 30, 2011

To: Mr. Michael Binkley, President

Provider: Su Vida Services, Inc.
Address: 8501 Candelaria, Building A
State/Zip: Albuquerque, New Mexico 87112

Cc (email): Ms. Patsy Rios, Su Vida Services, Inc.

Region: Metro, Northeast & Northwest
Survey Date: August 29 - September 2, 2011
Program Surveyed: Developmental Disabilities Waiver
Services Surveyed: Living Supports (Supported Living, Family Living & Independent Living) & Inclusion Supports (Adult Habilitation & Community Access)
Survey Type: Routine - Pilot

Dear Mr. Binkley:

The Division of Health Improvement Quality Management Bureau received, reviewed and approved the documents you submitted for your Plan of Correction.

The Plan of Correction process is now complete.

To maintain ongoing compliance with Standards and regulations, continue to implement the Quality Assurance/Quality Improvement processes described in your Plan of Correction, including:

- Direct Service Personnel tested annually on Individual-specific training requirements, achieving a 90% competency
- Presence of IST training documents to be verified as part of annual contractor/personnel file review
- Evidence of COR/EAR and CCHS clearances to be verified annually as part of annual contractor/personnel file review
- Internal Service Coordinators to review MARs for thoroughness and accuracy during monthly visits, and again at the end of each month
- Agency Nurse will review MARs monthly
- CQI sub-committee will review ISPs to determine the need for Healthcare and Crisis Plans
- CQI Committee to review all Significant Events and ANE Incident Reports weekly
- CQI Committee to review need for Human Rights Committee approvals
- Management to maintain a tracking matrix for all routine medical exams

- To ensure Billing is accurate, and that all required documentation to justify all Billing is present, documentation is reviewed by the Coordinator, then by the billing person. A review is also performed by the CFO and Billing Administrator

Consistent implementation of your QA/QI processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, and for the work you and your team perform.

Sincerely,

George Perrault, MBA
Plan of Correction Coordinator

Cc: DHI
DDSD