



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: September 6, 2011

To: Patrick Keptner, Executive Director
Provider: Tohatchi Area of Opportunity & Services, Inc.
Address: 161 South Catalpa Road
State/Zip: Gallup, New Mexico, 87301

E-mail Address: patkeptner@yahoo.com

CC: Johnnie Willeto Sr., Board Chair
Address: P.O. Box 21,
State/Zip: Tohatchi, New Mexico, 87325

Board Chair: aetsitty-27@yahoo.com

Region: Northwest
Survey Date: July 18 - 22, 2011
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)

Survey Type: Routine
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau
Dennis O'Keefe, Developmental Disability Specialists, Developmental Disabilities Supports Division

Dear Mr. Keptner;

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 contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

Quality Management Compliance Determination:

The Division of Health Improvement is issuing your agency a determination of "Substandard Compliance with Conditions of Participation."

Plan of Correction:

The attached Report of Findings identifies deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Please submit your agency's Plan of Correction in the



DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108
(505) 222-8623 • FAX: (505) 222-8661 • <http://www.dhi.health.state.nm.us>

QMB Report of Findings – Tohatchi Area of Opportunity & Services Inc. – Northwest Region – July 18 – 22, 2011

Survey Report #: Q12.01.D1703.NW.001.RTN.01

space on the two right columns of the Report of Findings. See attachment "A" for additional guidance in completing the Plan of Correction. The response is due to the parties below within 10 business days of the receipt of this letter:

- 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 within 45 business days. 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, complete or implement your Plan of Correction within the 45 day required time frames 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,

Tony Fragua, BFA

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

Survey Process Employed:

Entrance Conference Date: July 18, 2011

Present: **Tohatchi Area of Opportunity and Services, Inc.**

Patrick Keptner, Executive Director
Melinda Golden, Program Manager
Patricia Tapia, TAOS Training Coordinator
Doreen Kalleco, Service Coordinator

DOH/DHI/QMB

Anthony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

DDSD - Northwest Regional Office

Dennis O'Keefe, Developmental Disability Specialists, Developmental Disabilities Supports Division

Exit Conference Date: July 20, 2011

Present: **Tohatchi Area of Opportunity and Services, Inc.**

Melinda Golden, Program Manager
Kimber Crowe, Accounting Clerk
Maria Allison, Day Habilitation Supervisor
Deloria Bitsie, Chief Executive Officer Administration Assistant
Mary Hood, Life Skills Instructor
Artencia Begay, Human Resource Manager
Patricia Tapia, TAOS Training Coordinator
Doreen Kalleco, Service Coordinator

DOH/DHI/QMB

Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

DDSD - Northwest Regional Office

Dennis O'Keefe, Developmental Disability Specialists, Developmental Disabilities Supports Division

Total Homes Visited	Number:	5
❖ Supported Homes Visited	Number:	5
Administrative Locations Visited	Number:	3 - Administrative Offices: 161 South Catalpa Road, Gallup New Mexico 87301 Program Offices: 3006 Highway 66, Gallup New Mexico 87301 Health Department Offices: 100 Manuelito Drive, Tohatchi New Mexico 87325
Total Sample Size	Number:	6 0 - Jackson Class Members 6 - Non-Jackson Class Members 6 - Supported Living 6 - Adult Habilitation 5 - Community Access

QMB Report of Findings – Tohatchi Area of Opportunity & Services Inc. – Northwest Region – July 18 – 22, 2011

2 - Supported Employment

Persons Served Interviewed	Number:	6
Person Served Records Reviewed	Number:	6
Direct Service Professionals Record Review	Number:	74
Direct Service Professionals Interviewed	Number:	12
Service Coordinator Record Review	Number:	2

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
- DDS Performance Improvement Plan (PIP) 8/30/2011
- Quality Assurance/Quality Improvement Plan to address Trending and Incident Management quality request from IMB 5/25/2011

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

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 US 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 days will be referred to the Internal Review Committee [IRC] for 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 DDS Regional Office.

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) days of receiving your report. The POC process cannot resolve disputes regarding findings. 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. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

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 you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
 - 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, Root Cause Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

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). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 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.

Plan of Correction Submission Requirements

1. Your 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. If you have 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
 - b. Faxed to 505-222-8661, or
 - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
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 that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 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.
8. 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.

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, fax, or electronically on disc or 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; hard copies or scanned and electronically submitted copies are fine. 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.

QMB Scope and Severity Matrix

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Compliance Determination.

		SCOPE			
		Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%	
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

Scope and Severity Definitions:

- **Isolated:**
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.

- **Pattern:**
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.

- **Widespread:**
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.

QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. 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 Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of ‘Non-Compliance’ may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of ‘Substandard Compliance’ will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

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 that surveyors have clarified issues and/or requested missing information before completing the review. 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 working days** of receipt of the final report.
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.

The following limitations apply to the IRF process:

- The request for an IRF and all supporting evidence must be received within 10 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 QMB compliance determination or the length of their DDS provider contract.

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

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. 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: Tohatchi Area of Opportunity and Services, Inc. – Northwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
Date of Survey: July 18 - 22, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p>Tag # 1A07 SSI Payments</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>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.</p> <p>Code of Federal Regulations:</p> <p>§416.635 What are the responsibilities of your representative payee...</p>	<p>Scope and Severity Rating: C</p> <p>Based on record review, the Agency failed to maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds.</p> <p>Review of the Agency's policies & procedures found no evidence of a policy regarding individual SSI payments or other personal funds.</p> <p>The document provided to surveyors was a Client Personal Service transaction flow chart.</p> <ul style="list-style-type: none"> ◦ Document did not have policy statement ◦ Document did not have date or evidence of effective date ◦ Document did not have a signature or other evidence of approval 	<p><u>Provider:</u> 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.</p> <hr/>	

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 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).

Tag # 1A08 Agency Case File	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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; (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 	<p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 3 of 6 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain Individual's current address Information (#4) ◦ Did not contain current phone number Information (#4) • Occupational Therapy Plan (#5) • Physical Therapy Plan (#3) 	<p><u>Provider:</u> 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.</p> <hr/>

- 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 # 1A11 (CoP) Transportation P&P	Scope and Severity Rating: F		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>G. Transportation: Provider agencies that provide Community Living, Community Inclusion or Non-Medical Transportation services shall have a written policy and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and procedures must address at least the following topics:</p> <ol style="list-style-type: none"> (1) Drivers' requirements, (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (3) Vehicle maintenance and safety inspections, (4) Staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures, (5) Emergency Plans, including vehicle evacuation techniques, (6) Documentation, and (7) Accident Procedures. <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</p>	<p>Based on record review, the Agency failed to have a written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals.</p> <p>During review of Agency's policies and procedures the following elements were not found:</p> <ol style="list-style-type: none"> (2) Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions, (5) Emergency Plans, including vehicle evacuation techniques, 	<p><u>Provider:</u> 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.</p> <hr/>	

II. POLICY STATEMENTS:

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

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

Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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...</p> <p>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff Date: March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following:</p> <ol style="list-style-type: none"> 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) 	<p>Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 29 of 74 Direct Service Professionals.</p> <p>No documented evidence was found of the following required training:</p> <ul style="list-style-type: none"> • Transportation (DSP #48, 57, 55, 56, 58, 60, 61, 63, 65, 66, 69, 70, 75, 77, 78, 80, 82, 84, 85, 86, 89, 90, 91, 93, 104, 109, 115, 117 & 119) 	<p><u>Provider:</u> 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.</p> <hr/>

Tag # 1A15.2 & 5109 - Healthcare Documentation	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(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:</p> <ul style="list-style-type: none"> (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. <p>(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</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 6 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Care Plans <ul style="list-style-type: none"> ◦ <i>Oral care/Hygiene</i> <ul style="list-style-type: none"> ◦ Individual #1 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. ◦ Individual #2 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. ◦ Individual #4 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. • <i>Bowel/Bladder</i> <ul style="list-style-type: none"> ◦ Individual #1 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. • <i>Body Mass Index (BMI)</i> <ul style="list-style-type: none"> ◦ Individual #2 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. • <i>Falls</i> <ul style="list-style-type: none"> ◦ Individual #2 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. ◦ Individual #5 - According to the Individual's current E-CHAT the individual is required to 	<p><u>Provider:</u> 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.</p>	

<p>agency nurse must be available to assist the caregiver upon request.</p> <p>(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.</p> <p>(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).</p> <p>(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 <i>subjective</i> information including the individual complaints, signs and symptoms noted by staff, family members or other team members; <i>objective</i> information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); <i>assessment</i> of the clinical status, and <i>plan</i> of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.</p> <p>(2) Health related plans</p> <p>(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</p>	<p>have a plan. No evidence of a plan found.</p> <ul style="list-style-type: none"> • <i>GI-Constipation Management</i> <ul style="list-style-type: none"> ◦ Individual #5 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. • Crisis Plans/Medical Emergency Response Plans <ul style="list-style-type: none"> • <i>Falls</i> <ul style="list-style-type: none"> ◦ Individual #2 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. ◦ Individual #5 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. • <i>Hypertension</i> <ul style="list-style-type: none"> ◦ Individual #4 - According to the Individual's current E-CHAT the individual is required to have a plan. No evidence of a plan found. • Other <ul style="list-style-type: none"> ◦ Review of the Medical Emergency Response Plans (Crisis Prevention Plan) for Individual #4 found the following components were not addressed as required by the DDSD Medical Emergency Response Plans Policy effective 8/1/10: <ul style="list-style-type: none"> F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: <ul style="list-style-type: none"> 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. 	
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<p>professional.</p> <p>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.</p> <p>(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.</p> <p>(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.</p> <p>(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):</p> <p>(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.</p> <p>(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.</p> <p>(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</p>			
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<p>shall be specified in the plan.</p> <p>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.</p> <p>(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.</p> <p>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.</p> <p>(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.</p> <p>(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.</p> <p>(4) General Nursing Documentation</p> <p>(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.</p> <p>(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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p>			
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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...

Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>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.</p> <p>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDS/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</p> <p>(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</p> <p>(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.</p> <p>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:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 28 of 74 Direct Service Professionals.</p> <p>Review of Direct Service Professionals training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</p> <ul style="list-style-type: none"> • Foundation for Health & Wellness (DSP #73 & 119) • Person-Centered Planning (1-Day) (DSP #119) • First Aid (DSP #43, 50, 56, 59, 60, 61, 63, 65, 66, 69, 77, 80, 90, 93, 97 & 115) • CPR (DSP #43, 49, 50, 56, 59, 60, 61, 63, 65, 66, 69, 71, 77, 80, 90, 93, 97 & 115) • Assisting With Medication Delivery (DSP #44, 70, 79, 80, 81 & 115) • Participatory Communication & Choice Making (DSP #59, 64, 70, 73, 75, 76, 77, 79 & 119) • Rights & Advocacy (DSP #73 & 119) • Level 1 Health (DSP #73, 75, 79, 80 & 119) • Positive Behavior Supports Strategies (DSP #70) • Teaching & Support Strategies (DSP #59, 73, 80 & 119) 	<p><u>Provider:</u> 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.</p> <hr/>

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 services.

Tag # 1A22 Staff Competence	Scope and Severity Rating: F	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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 	<p>Based on interview, the Agency failed to ensure that training competencies were met for 10 of 12 Direct Service Professionals.</p> <p>When DSP were asked if they received training on the Individual's ISP and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #109 stated, "No, I just started last week Monday in this Apartment." (Individual #4) • DSP #70 stated, "No, I just read his ISP myself." (Individual #6) <p>When DSP were asked if they received training on the Individual's Positive Behavioral Supports Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #91 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #3) <p>When DSP were asked if they received training on the Individual's Occupational Therapy Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #91 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #3) <p>When DSP were asked if they received training on the Individual's Health Care Plans and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #46 stated, "No." As indicated by the Agency file, the Individual has Health Care Plans for Hypertension, Aspiration. (Individual #1) 	<p><u>Provider:</u> 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.</p> <hr/>

<p>Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and</p> <p>(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.</p> <p>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:</p> <p>(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;</p> <p>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and</p> <p>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.</p> <p>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:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p>	<ul style="list-style-type: none"> • DSP #49 stated, "Some, I'm not sure what."As indicated by the Agency file, the Individual has Health Care Plans for Aspiration, Oral Care & Seizures. (Individual #5) • DSP #78 stated, "Yes, she has one, Aspiration; but no, I'm not trained on them."As indicated by the Agency file, the Individual has Health Care Plans for Hypertension & Williams Syndrome. (Individual #4) • DSP #81 stated, "Yes, Aspiration." As indicated by the Agency file, the Individual has Health Care Plans for Hypertension. (Individual #1) • DSP #84 stated, "No."As indicated by the Agency file, the Individual has Health Care Plans for Aspiration, Oral Care, Seizures. (Individual #5) • DSP #91 stated, "Yes, there are plans for Seizures & Aspiration; but no, I'm not trained on them." As indicated by the Agency file, the Individual has Health Care Plans for Oral Care, Skin/Wounds, Constipation, Bowel/Bladder & Cerebral Palsy. (Individual #3) • DSP #109 stated, "No."As indicated by the Agency file, the Individual has Health Care Plans for Hypertension & Williams Syndrome. (Individual #4) • DSP #117 stated, "Yes, Seizures & Aspiration." As indicated by the Agency file, the Individual has Health Care Plans for Oral Care, Skin/Wounds, Constipation, Bowel/Bladder & Cerebral Palsy. Staff did not mention these HCP plans for (Individual #3) • DSP #114 stated, "No."As indicated by the Agency file, the Individual has Health Care Plans for Hypertension. (Individual #6) 		
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	<ul style="list-style-type: none"> • DSP #70 stated, “No.”As indicated by the Agency file, the Individual has Health Care Plans for Hypertension. (Individual #6) <p>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:</p> <ul style="list-style-type: none"> • DSP #46 stated, “No.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Hypertension. (Individual #1) • DSP #70 stated, “No.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Hypertension. (Individual #6) • DSP #78 stated, “Yes, she has crisis plans, no I’m not trained on them.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Hypertension. (Individual #4) • DSP #81 stated, “No, not yet.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Hypertension. (Individual #1) • DSP #91 stated, “Yes there are crisis plans, no I’m not trained on them.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Aspiration, Seizures & Asthma. (Individual #3) • DSP #109 stated, “No.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Hypertension. (Individual #4) 		
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	<ul style="list-style-type: none"> • DSP #114 stated, “No.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Hypertension. (Individual #6) • DSP #117 stated, “No.” As indicated by the Agency file, the Individual has Crisis Plans/Medical Emergency Response Plan for Aspiration, Seizures & Asthma. (Individual #3) <p>When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:</p> <ul style="list-style-type: none"> • DSP #70 stated, “Take his temperature.” According to DDS Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP) (Individual #6) <p>When DSP were asked what the individual’s Diagnosis were, the following was reported:</p> <ul style="list-style-type: none"> • DSP #70 stated, “No I don’t know.” According to the individuals ISP he is diagnosed with Hypertension, Cardiac condition & Cataract removal. (Individual #6) <p>When DSP were asked to describe the signs and symptoms of an adverse reaction to a medication, the following was reported:</p> <ul style="list-style-type: none"> • DSP #70 stated, “Rolling eyes back and fever.” DSP did not indicate the reaction could be life threatening. (Individual #6) 		
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When DSP were asked to describe the signs and symptoms of an Allergic Reaction to food, the following was reported:

- DSP #70 stated, "Rolling eyes back and fever."
DSP did not indicate the reaction could be life threatening (Individual #6)

Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	
<p>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.</p> <p>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.</p> <p>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.</p>	<p>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 9 of 76 Agency Personnel.</p> <p>The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:</p> <ul style="list-style-type: none"> • #94 – Date of hire 4/28/2011 • #95 – Date of hire 5/3/2011 • #96 – Date of hire 5/10/2011 • #97 – Date of hire 5/16/2011 • #98 – Date of hire 5/18/2011 • #99 – Date of hire 5/18/2011 • #100 – Date of hire 5/18/2011 • #101 – Date of hire 5/27/2011 <p>The following Agency Personnel Files contained Caregiver Criminal History Screenings, which were not specific to the Agency:</p> <ul style="list-style-type: none"> • #91 – Date of hire 4/6/2011 	<p><u>Provider:</u> 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.</p>

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 22 of 76 Agency Personnel.</p> <p>The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:</p> <ul style="list-style-type: none"> • #112 – Date of hire 6/21/2011 <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #69 – Date of hire 4/7/2009. Completed 11/4/2009. • #71 – Date of hire 6/25/2009. Completed 11/4/2009. • #73 – Date of hire 9/15/2009. Completed 3/10/2010. • #81 – Date of hire 6/24/2010. Completed 7/21/2011. • #85 – Date of hire 8/21/2010. Completed 9/17/2010. • #89 – Date of hire 2/14/2011. Completed 3/10/2011. • #90 – Date of hire 4/5/2011. Completed 7/21/2011. • #94 – Date of hire 4/28/2011. Completed 7/21/2011. • #95 – Date of hire 5/3/2011. Completed 	<p><u>Provider:</u> 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.</p> <hr/>

respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance.** The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars (\$5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007
Chapter 1.IV. General Provider Requirements.
D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

7/21/2011.

- #96 – Date of hire 5/10/2011. Completed 7/21/2011.
- #98 – Date of hire 5/18/2011. Completed 7/21/2011.
- #99 – Date of hire 5/18/2011. Completed 7/21/2011.
- #100 – Date of hire 5/18/2011. Completed 7/21/2011.
- #101 – Date of hire 5/27/2011. Completed 7/21/2011.
- #102 – Date of hire 6/2/2011. Completed 7/21/2011.
- #103 – Date of hire 6/7/2011. Completed 7/21/2011.
- #104 – Date of hire 6/7/2011. Completed 7/21/2011.
- #105 – Date of hire 6/7/2011. Completed 7/21/2011.
- #106 – Date of hire 6/7/2011. Completed 7/21/2011.
- #109 – Date of hire 6/20/2011. Completed 7/21/2011.
- #118 – Date of hire 5/10/2011. Completed 7/1/2011.

Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E	
<p>7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:</p> <p>A. Duty To Report:</p> <p>(1) All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.</p> <p>(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:</p> <p>(a) an environmental hazardous condition, which creates an immediate threat to life or health; or</p> <p>(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.</p> <p>(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.</p> <p>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.</p>	<p>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 4 of 10 individuals.</p> <p>Individual #7</p> <ul style="list-style-type: none"> Incident date 10/26/2010. Allegation was Neglect. Incident report was received 10/29/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #8</p> <ul style="list-style-type: none"> Incident date 11/9/2010. Allegation was Neglect. Incident report was received 11/12/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #9</p> <ul style="list-style-type: none"> Incident date 11/9/2010. Allegation was Neglect. Incident report was received 11/12/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." <p>Individual #10</p> <ul style="list-style-type: none"> Incident date 11/9/2010. Allegation was Neglect. Incident report was received 11/12/2010. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." Incident date 12/20/2010. Allegation was Neglect/Environmental Hazard. Incident report was received 4/15/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." 	<p><u>Provider:</u> 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.</p> <hr/>

Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review, the Agency failed to provide documentation verifying completion of initial or annual Incident Management Training for 13 of 76 Agency Personnel.</p> <p>Direct Service Professional Personnel (DSP):</p> <ul style="list-style-type: none"> • Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#43, 53, 55, 58, 59, 61, 68 & 109) <p>When Direct Service Professionals were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:</p> <ul style="list-style-type: none"> • DSP #46 stated, "Department of Health, Supervisor & C.O." DSP did not state APS. • DSP #70 stated, "I can't remember what that one is, I would report it." DSP did not state DHI and APS. • DSP #77 stated, "IMB, I don't remember which one. We fill out the form and give to monitor, they send it out." DSP did not state APS. • DSP #109 stated, "The Nursing Department." DSP did not state DHI and APS. • DSP #114 stated, "My supervisor, Case Management, make the call, told to take to management. No I really don't know." DSP did not state DHI and APS. • DSP #117 stated, "Not sure, I think its Northeast agency, I would not be afraid to call in an IR if needed." DSP did not state DHI and APS. 	<p><u>Provider:</u> 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.</p>

When DSP were asked to give examples of Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:

- DSP #70 stated, "Hitting is abuse, Neglect. What is that? Exploitation...No? "

Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope & Severity Rating: E		
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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.</p> <p>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.</p>	<p>Based on record review, the Agency failed to provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Misappropriation of Consumers' Property, for 4 of 6 individuals.</p> <ul style="list-style-type: none"> • Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#1, 3, 4 & 6) 	<p><u>Provider:</u> 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.</p> <hr/>	

Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B		
<p>NMAC 7.26.3.6 A. 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].</p> <p>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]</p> <p>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</p>	<p>Based on record review, the Agency failed to provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 4 of 6 individuals.</p> <ul style="list-style-type: none"> Grievance/Complaint Procedure Acknowledgement (#1, 3, 4 & 6) 	<p>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.</p> <hr/>	

Tag # 1A32 & 6L14 (CoP) ISP Implementation	Scope and Severity Rating: E	
<p>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<p>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 2 of 6 individuals.</p> <p>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Residential Files Reviewed:</p> <p>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #5</p> <ul style="list-style-type: none"> • None found for 7/1 – 17, 2011 <p>Individual #6</p> <ul style="list-style-type: none"> • None found for 7/1 – 17, 2011 	<p><u>Provider:</u> 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.</p>

Tag # 1A36 Service Coordination	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE</p> <p>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.</p> <p>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:</p> <p>(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</p> <p>NMAC 7.26.5.7 “service coordinator”: the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency</p> <p>NMAC 7.26.5.11 (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the</p>	<p>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators.</p> <p>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</p> <ul style="list-style-type: none"> • Pre-Service Manual (SC #123) 	<p>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.</p> <hr/>

service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows:

- (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
- (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
- (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
- (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;

Tag # 5I11.1 Reporting Requirements (CI Quarterly Report Components)	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS</p> <p>E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation:</p> <p>(1) Identification and implementation of a meaningful day definition for each person served;</p> <p>(2) Documentation summarizing the following:</p> <p>(a) Daily choice-based options; and</p> <p>(b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.</p> <p>(3) Significant changes in the individual's routine or staffing;</p> <p>(4) Unusual or significant life events;</p> <p>(5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs;</p> <p>(6) Record of personally meaningful community inclusion;</p> <p>(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</p> <p>(8) Any additional reporting required by DDSD.</p>	<p>Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 4 of 6 individuals receiving Community Inclusion Services.</p> <p>Review of quarterly reports found the following components were not addressed, as required:</p> <p><i>Individual #1, 2, 5 - The following components were not found in the Adult Habilitation & Community Access Quarterly Report for 1/2011 - 6/2011:</i></p> <p>1) Timely completion of relevant activities from ISP Action Plans</p> <p>3) Significant changes in routine or staffing;</p> <p>4) Unusual or significant life events;</p> <p>5) Updates on health status, including medication, assistive technology needs and durable medical equipment needs identified during the quarter; and</p> <p>7) Identification and implementation of a meaningful day definition for each person served;</p> <p><i>Individual #4 - The following components were not found in the Community Access Quarterly Report for 1/2011 - 6/2011:</i></p> <p>1) Timely completion of relevant activities from ISP Action Plans</p> <p>3) Significant changes in routine or staffing;</p> <p>4) Unusual or significant life events;</p> <p>5) Updates on health status, including medication, assistive technology needs and durable medical</p>	<p><u>Provider:</u> 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.</p>

	<p>equipment needs identified during the quarter; and</p> <p>7) Identification and implementation of a meaningful day definition for each person served;</p>		
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Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS</p>	<p>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 5 individuals.</p> <p>Individual #1 February 2011</p> <ul style="list-style-type: none"> • The Agency billed 17 units of Community Access from 2/6/2011 through 2/12/2011. Documentation received accounted for 15 units. • The Agency billed 11 units of Community Access from 2/13/2011 through 2/19/2011. Documentation received accounted for 8 units. <p>March 2011</p> <ul style="list-style-type: none"> • The Agency billed 18 units of Community Access from 2/27/2011 through 3/05/2011. Documentation received accounted for 15 units. • The Agency billed 33 units of Community Access from 3/6/2011 through 3/12/2011. Documentation received accounted for 16 units. • The Agency billed 29 units of Community Access from 3/13/2011 through 3/19/2011. Documentation received accounted for 23 units. • The Agency billed 22 units of Community Access from 3/20/2011 through 3/26/2011. Documentation received accounted for 16 units. <p>April 2011</p> <ul style="list-style-type: none"> • The Agency billed 23 units of Community Access from 3/27/2011 through 4/23/2011. Documentation received accounted for 19 units. <p>Individual #5 March 2011</p> <ul style="list-style-type: none"> • The Agency billed 18 units of Community Access from 2/27/2011 through 3/05/2011. No 	<p><u>Provider:</u> 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.</p>

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.

documentation found to justify billing.

- The Agency billed 21 units of Community Access from 3/06/2011 through 3/12/2011. No documentation found to justify billing.
- The Agency billed 10 units of Community Access from 3/13/2011 through 3/19/2011. No documentation found to justify billing.
- The Agency billed 20 units of Community Access from 3/20/2011 through 3/26/2011. Documentation received accounted for 4 units.

Tag # 5144 AH Reimbursement	Scope and Severity Rating: A	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>MAD-MR: 03-59 Eff 1/1/2004</p> <p>8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</p> <p>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.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 XVI. REIMBURSEMENT</p> <p>A. Billable Unit. A billable unit for Adult Habilitation</p>	<p>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 1 of 6 individuals.</p> <p>Individual #2 February 2011</p> <ul style="list-style-type: none"> • The Agency billed 106 units of Adult Habilitation from 2/13/2011 through 2/19/2011. Documentation received accounted for 89 units. <p>March 2011</p> <ul style="list-style-type: none"> • The Agency billed 116 units of Adult Habilitation from 3/13/2011 through 3/19/2011. Documentation received accounted for 24 units. <p>April 2011</p> <ul style="list-style-type: none"> • The Agency billed 108 units of Adult Habilitation from 3/27/2011 through 4/02/2011. Documentation received accounted for 96 units. 	<p><u>Provider:</u> 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.</p> <hr/>

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

Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING</p> <p>G. Health Care Requirements for Community Living Services.</p> <p>(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.</p> <p>(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.</p> <p>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:</p> <p>(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.</p> <p>b) That each individual with a score of 4, 5, or 6</p>	<p>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 1 of 6 individuals receiving Community Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Dental Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 7/15/2010. Follow-up was to be completed in 6 months. No evidence of follow-up found. • Vision Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by the DDS file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by collateral documentation reviewed, exam was completed on 5/12/2010. Follow-up was to be completed in 1 year. No evidence of follow-up found. • Pap Smear Exam <ul style="list-style-type: none"> ◦ Individual #4 - As indicated by collateral documentation reviewed, exam was referred on 6/23/2011 by Doctor. No evidence of exam being scheduled was found. 	<p><u>Provider:</u> 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.</p> <hr/>

<p>on the HAT, has a Health Care Plan developed by a licensed nurse.</p> <p>(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.</p> <p>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.</p> <p>(5) That the physical property and grounds are free of hazards to the individual's health and safety.</p> <p>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:</p> <p>(a) The individual has a primary licensed physician;</p> <p>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;</p> <p>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).</p> <p>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.</p>			
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Tag # 6L14 Residential Case File	Scope and Severity Rating: E	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>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:</p> <p>(1) Complete and current ISP and all supplemental plans specific to the individual;</p> <p>(2) Complete and current Health Assessment Tool;</p> <p>(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;</p> <p>(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);</p> <p>(5) Data collected to document ISP Action Plan implementation</p> <p>(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;</p> <p>(7) Physician's or qualified health care providers written orders;</p> <p>(8) Progress notes documenting implementation of</p>	<p>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 5 of 6 Individuals receiving Supported Living Services.</p> <p>The following was not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Current Emergency & Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain current address Information (#4 & 6) ◦ Did not contain current phone number Information (#4 & 6) • Speech Therapy Plan (#4) • Special Health Care Needs <ul style="list-style-type: none"> ◦ Nutritional Plan (#4 & 6) • Health Care Plans <ul style="list-style-type: none"> ◦ Aspiration (#5) ◦ Hypertension (#6) ◦ Oral Care (#5) ◦ Seizures (#5) • Crisis Plan <ul style="list-style-type: none"> ◦ Aspiration (#5) ◦ Cardiac Condition (#6) ◦ Seizures (#5) • Progress Notes/Daily Contacts Logs: <ul style="list-style-type: none"> ◦ Individual #2 - None found for 7/1 – 17, 2011. ◦ Individual #4 - None found for 7/1 – 17, 2011. ◦ Individual #5 - None found for 7/1 – 17, 2011. ◦ Individual #6 - None found for 7/1 – 17, 2011. 	<p><u>Provider:</u> 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.</p> <hr/>

<p>a physician's or qualified health care provider's order(s);</p> <p>(9) Medication Administration Record (MAR) for the past three (3) months which includes:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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. <p>(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</p> <p>(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</p>	<ul style="list-style-type: none"> • Progress Notes written by DSP and/or Nurses regarding Health Status: <ul style="list-style-type: none"> ◦ Individual #2 - None found for 7/1 – 17, 2011. ◦ Individual #4 - None found for 7/1 – 17, 2011. ◦ Individual #5 - None found for 7/1 – 17, 2011. ◦ Individual #6 - None found for 7/1 – 17, 2011. • Health Care Providers Written Orders (#1, 2, 4, 5 & 6) • Record of visits of healthcare practitioners (#2, 4, 5 & 6) 		
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discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.

Tag # 6L17.1 Reporting Requirements (CL Quarterly Report Components)	Scope and Severity Rating: C	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>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:</p> <p>(1) Timely completion of relevant activities from ISP Action Plans</p> <p>(2) Progress towards desired outcomes in the ISP accomplished during the quarter;</p> <p>(3) Significant changes in routine or staffing;</p> <p>(4) Unusual or significant life events;</p> <p>(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and</p> <p>(6) Data reports as determined by IDT members.</p>	<p>Based on record review, the Agency failed to complete written quarterly status reports in compliance with standards for 6 of 6 individuals receiving Community Living Services.</p> <p>Review of quarterly reports found the following components were not addressed as required:</p> <p><i>Individual #1, 2, 3, 4, 5 & 6 - The following were not found in the Supported Living Quarterly Report for 1/2011 - 6/2011:</i></p> <p>(3) Significant changes in routine or staffing;</p> <p>(4) Unusual or significant life events;</p> <p>(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and</p> <p>(6) Data reports as determined by IDT members.</p>	<p><u>Provider:</u> 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.</p> <hr/>

Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:</p> <ul style="list-style-type: none"> (a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence; (b) General-purpose first aid kit; (c) When applicable due to an individual's health status, a blood borne pathogens kit; (d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats; (e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone; (f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift; (g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP; and (h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 1 of 6 Supported Living residences.</p> <p>The following items were not found, not functioning or incomplete:</p> <p>Supported Living Requirements:</p> <ul style="list-style-type: none"> • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#6) 	<p><u>Provider:</u> 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.</p> <hr/>	

<p>Tag # 6L25.1 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)</p>	<p>Scope and Severity Rating: D</p>	
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</p> <p>L. Residence Requirements for Family Living Services and Supported Living Services</p> <p>(2) Overall each residence shall maintain basic utilities, i.e., gas, power, water, telephone at the residence and shall maintain the physical environment in a safe and comfortable manner for the individuals.</p> <p>(3) Each individual shall have access to all household equipment and cleaning supplies unless precluded by his or her ISP.</p> <p>(4) Living and Dining Areas shall</p> <ul style="list-style-type: none"> (a) Provide individuals free use of all space with due regard for privacy, personal possessions and individual interests; (b) Maintain areas for the usual functions of daily living, social, and leisure activities in a clean and sanitary condition; and (c) Provide environmental accommodations based on the unique needs of the individual. <p>(5) Kitchen area shall:</p> <ul style="list-style-type: none"> (a) Possess equipment, utensils, and supplies to properly store, prepare, and serve at least three (3) meals a day; (b) Arrangements will be made, in consultation with the IDT for environmental accommodations and assistive technology devices specific to the needs of the individual(s); and (c) Water temperature is required to be maintained at a safe level to both prevent 	<p>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard, which maintains a physical environment which is safe and comfortable for 1 of 5 Supported Living residences. (Individuals #3 & 5)</p> <p>Supported Living Requirements:</p> <p>During on-site visit (July 18, 2011; 4:45pm), surveyors observed the following:</p> <p>During interviews, When DSP #49 was asked if there were any Health or Safety related needs not being addressed by the Agency, the following was reported.</p> <ul style="list-style-type: none"> • DSP #49 stated “does not have appropriate shower.” <p>Surveyors observed the roll in shower was not accessible due to high lip used to retain water. When Surveyors asked about the high lip DSP #49 reported they had tried using the shower on more than one occasion but due to the shower chair “nearly tipping.” Because of the potential to tipping over DSP reported it was decided for health and safety reasons the DSP's would give individuals in the home sponge baths.</p> <p>Additionally, Surveyors observed doors to bedrooms, bathrooms and several walls were damaged by the wheelchairs due to the difficulty on maneuvering through the hallways in the rear of the apartment.</p> <p>Also noted was a closet door which was off of its sliding rails; and doors were leaning up against the bedroom walls.</p>	<p><u>Provider:</u> 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.</p> <hr/>

<p>injury and ensure comfort.</p> <p>(6) Bedroom area shall:</p> <p>(a) At a maximum of two (2) individuals share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;</p> <p>(b) All bedrooms shall have doors, which may be closed for privacy</p> <p>(c) Physical arrangement of bedrooms compatible with the physical needs of the individual; and</p> <p>(d) Allow individuals the right to decorate his or her bedroom in a style of his or her choice consistent with a safe and sanitary living conditions.</p> <p>(7) Bathroom area shall provide:</p> <p>(a) For Supported Living, a minimum of one toilet and lavatory facility for every two (2) individuals with Developmental Disabilities living in the home;</p> <p>(b) Reasonable modifications or accommodations, based on the physical needs of the individual (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.):</p> <p>(i) Toilets, tubs, showers used by the individual(s) provide for privacy; designed or adapted for the safe provision of personal care; and</p> <p>(ii) Water temperature maintained at a safe level to prevent injury and ensure comfort.</p>	<p>When asked about this DSP reported the doors came off soon after moving into the apartment.</p> <p>The pin-style-hinge that would hold the doors on were bent and would need replaced.</p> <p>During the observation DSP also expressed the following concerns to Surveyors:</p> <ul style="list-style-type: none"> • The phone was installed a week prior of surveyors visit. Individuals had been living in residence for approximately one month. • The residence did not have sufficient groceries for one week because "...takes too many steps to get money to shop," and they were not allowed to borrow supplies from other near by apartments. • There is "no driver" in evenings. Leading to the inability to go on outings. 		
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SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: March 20, 2012

To: Patrick Keptner, Executive Director
Provider: Tohatchi Area of Opportunity & Services, Inc.
Address: 161 South Catalpa Road
State/Zip: Gallup, New Mexico, 87301

E-mail Address: patkeptner@yahoo.com

CC: Johnnie Willeto Sr., Board Chair
Address: P.O. Box 21,
State/Zip: Tohatchi, New Mexico, 87325

Board Chair: aetsitty-27@yahoo.com

Region: Northwest
Routine Survey: July 18 - 22, 2011
Verification Survey: February 28, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)

Survey Type: Verification
Team Leader: Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members: Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

Dear Mr. Keptner;

The Division of Health Improvement/Quality Management Bureau has completed a verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the Routine Survey on July 18 – 22, 2011. The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

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. These findings will be reviewed by the DOH – Internal Review Committee during an upcoming review meeting. The findings are attached. You will be contacted by the Department for further instructions regarding your plan of correction requirements.

Please call the Plan of Correction Coordinator at 505-222-8647, if you have questions about the survey or the report.

Thank you for your cooperation and for the work you perform.



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

QMB Report of Findings – Tohatchi Area of Opportunity & Services Inc. – Northwest Region – February 28, 2012

Survey Report #: Q12.03.D1703.NW.001.VS.01

Sincerely,

Tony Fragua, BFA

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

Survey Process Employed:

Entrance Conference Date: February 28, 2012

Present: **Tohatchi Area of Opportunity and Services, Inc.**
Patrick Keptner, Executive Director

DOH/DHI/QMB

Anthony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

Exit Conference Date: February 28, 2012

Present: **Tohatchi Area of Opportunity and Services, Inc.**
Patrick Keptner, Executive Director

Melinda Golden, Quality Assurance Analyst
Kimber Crowe, Client Service Coordinator
Terrilyn Williams, TAOS Training Coordinator
Doreen Kalleco, Service Coordinator

DOH/DHI/QMB

Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Scott Good, MRC, CRC, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau

Total Homes Visited	Number:	2
❖ Supported Homes Visited	Number:	2
Administrative Locations Visited	Number:	3 - Administrative Offices: 161 South Catalpa Road, Gallup New Mexico 87301 Program Offices: 1640 South 2nd, Gallup New Mexico 87301 Chuska Apartment Office: Apt. 4C, 2534 East Aztec, Gallup New Mexico 87301
Total Sample Size	Number:	6 0 - Jackson Class Members 6 - Non-Jackson Class Members 6 - Supported Living 6 - Adult Habilitation 5 - Community Access 2 - Supported Employment
Person Served Records Reviewed	Number:	6
Direct Service Professionals Record Review	Number:	80
Direct Service Professionals Interviewed	Number:	14
Service Coordinator Record Review	Number:	1
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
- Policy on Processing & Recording of Client Personal Service Transaction

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

QMB Determinations of Compliance

- “Compliance with Conditions of Participation”
The QMB determination of “Compliance with Conditions of Participation,” indicates that a provider is in compliance with all ‘Conditions of Participation,’ (CoP) but may have standard level deficiencies (deficiencies which are not at the condition level) out of compliance. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Compliance with Conditions of Participation, the provider must be in compliance with *all* Conditions of Participation.
- “Partial-Compliance with Conditions of Participation”
The QMB determination of “Partial-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) to three (3) ‘Conditions of Participation.’ This partial-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety. The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

- “Non-Compliant with Conditions of Participation”:
The QMB determination of “Non-Compliance with Conditions of Participation,” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
 - Four (4) Conditions of Participation out of compliance.
 - Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
 - Any finding of actual harm or Immediate Jeopardy.The Agency may also have standard level deficiencies (deficiencies which are not at the condition level).

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

**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:

5. 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.
6. 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>
7. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
8. 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: Tohatchi Area of Opportunity and Services, Inc. – Northwest Region
Program: Developmental Disabilities Waiver
Service: Community Living (Supported Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Verification Survey
Routine Survey: July 18 - 22, 2011
Verification Survey: February 28, 2012

Standard of Care	July 18 - 22, 2011 Deficiencies	February 28, 2012 Verification Survey – New and Repeat Deficiencies
Tag # 1A15.2 & 5109 - Healthcare Documentation	Scope and Severity Rating: E	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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.</p> <p>Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities</p> <p>(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:</p> <ul style="list-style-type: none"> (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. <p>(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</p>	<p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 4 of 6 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Care Plans <ul style="list-style-type: none"> • <i>Oral care/Hygiene</i> <ul style="list-style-type: none"> ◦ Individual #1 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found. ◦ Individual #2 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found. ◦ Individual #4 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found. • <i>Bowel/Bladder</i> <ul style="list-style-type: none"> ◦ Individual #1 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found. 	<p>New and Repeat Findings:</p> <p>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 6 individual</p> <p>The following were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> • Health Care Plans <ul style="list-style-type: none"> • <i>Body Mass Index (BMI)</i> <ul style="list-style-type: none"> ◦ Individual #2 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found. • <i>Falls</i> <ul style="list-style-type: none"> ◦ Individual #5 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.

individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual's Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

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

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

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

- **Body Mass Index (BMI)**
 - Individual #2 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
- **Falls**
 - Individual #2 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
 - Individual #5 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
- **GI-Constipation Management**
 - Individual #5 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
- **Crisis Plans/Medical Emergency Response Plans**
 - **Falls**
 - Individual #2 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
 - Individual #5 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
 - **Hypertension**
 - Individual #4 - According to the Individual's current e-CHAT the individual is required to have a plan. No evidence of a plan found.
- **Other**
 - Review of the Medical Emergency Response Plans (Crisis Prevention Plan) for Individual #4 found the following components were not addressed as required by the DDSD Medical Emergency Response Plans Policy effective

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

8/1/10:

F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:

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.

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...

Tag # 1A26 (CoP) COR / EAR	Scope and Severity Rating: E	Standard Level Deficiency
<p>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</p> <p>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</p> <p>B. Prohibited employment. A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider.</p> <p>D. Documentation of inquiry to registry. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.</p> <p>E. Documentation for other staff. With</p>	<p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 22 of 76 Agency Personnel.</p> <p>The following Agency personnel records contained no evidence of the Employee Abuse Registry being completed:</p> <ul style="list-style-type: none"> • #112 – Date of hire 6/21/2011 <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #69 – Date of hire 4/7/2009. Completed 11/4/2009. • #71 – Date of hire 6/25/2009. Completed 11/4/2009. • #73 – Date of hire 9/15/2009. Completed 3/10/2010. • #81 – Date of hire 6/24/2010. Completed 7/21/2011. • #85 – Date of hire 8/21/2010. Completed 9/17/2010. • #89 – Date of hire 2/14/2011. Completed 3/10/2011. • #90 – Date of hire 4/5/2011. Completed 7/21/2011. • #94 – Date of hire 4/28/2011. Completed 7/21/2011. • #95 – Date of hire 5/3/2011. Completed 	<p>New and Repeat Findings:</p> <p>Based on record review, the Agency failed to maintain documentation in the employee's personnel records that evidenced inquiry to the Employee Abuse Registry prior to employment for 2 of 81 Agency Personnel.</p> <p>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry was completed after hire:</p> <ul style="list-style-type: none"> • #127 – Date of hire 9/2/2011. Completed 1/16/2012. • #129 – Date of hire 10/03/2011. Completed 10/05/2011.

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

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

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

Chapter 1.IV. General Provider Requirements.

D. Criminal History Screening: All personnel shall be screened by the Provider Agency in regard to the employee's qualifications, references, and employment history, prior to employment. All Provider Agencies shall comply with the Criminal Records Screening for Caregivers 7.1.12 NMAC and Employee Abuse Registry 7.1.12 NMAC as required by the Department of Health, Division of Health Improvement.

7/21/2011.

- #96 – Date of hire 5/10/2011. Completed 7/21/2011.
- #98 – Date of hire 5/18/2011. Completed 7/21/2011.
- #99 – Date of hire 5/18/2011. Completed 7/21/2011.
- #100 – Date of hire 5/18/2011. Completed 7/21/2011.
- #101 – Date of hire 5/27/2011. Completed 7/21/2011.
- #102 – Date of hire 6/2/2011. Completed 7/21/2011.
- #103 – Date of hire 6/7/2011. Completed 7/21/2011.
- #104 – Date of hire 6/7/2011. Completed 7/21/2011.
- #105 – Date of hire 6/7/2011. Completed 7/21/2011.
- #106 – Date of hire 6/7/2011. Completed 7/21/2011.
- #109 – Date of hire 6/20/2011. Completed 7/21/2011.
- #118 – Date of hire 5/10/2011. Completed 7/1/2011.

Tag # 1A28.1 (CoP) Incident Mgt. System - Personnel Training	Scope & Severity Rating: E	Standard Level Deficiency
<p>NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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.</p> <p>D. Training Documentation: All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee's training for a period of at least twelve (12) months, or six (6) months after termination of an employee's employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007</p> <p>II. POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>	<p>Based on record review, the Agency failed to provide documentation verifying completion of initial or annual Incident Management Training for 13 of 76 Agency Personnel.</p> <p>Direct Service Professional Personnel (DSP):</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#43, 53, 55, 58, 59, 61, 68 & 109) <p>When Direct Service Professionals were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:</p> <ul style="list-style-type: none"> DSP #46 stated, "Department of Health, Supervisor & C.O." DSP did not state APS. DSP #70 stated, "I can't remember what that one is, I would report it." DSP did not state DHI and APS. DSP #77 stated, "IMB, I don't remember which one. We fill out the form and give to monitor, they send it out." DSP did not state APS. DSP #109 stated, "The Nursing Department." DSP did not state DHI and APS. DSP #114 stated, "My supervisor, Case Management, make the call, told to take to management. No I really don't know." DSP did not state DHI and APS. DSP #117 stated, "Not sure, I think its Northeast agency, I would not be afraid to call in an IR if needed." DSP did not state DHI and APS. 	<p>New and Repeat Findings:</p> <p>Based on record review, the Agency failed to provide documentation verifying completion of initial or annual Incident Management Training for 1 of 81 Agency Personnel.</p> <p>Direct Service Professional Personnel (DSP):</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#132)

When DSP were asked to give examples of Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:

- DSP #70 stated, "Hitting is abuse, Neglect. What is that? Exploitation...No? "

Standard of Care	July 18 - 22, 2011 Deficiencies	February 28, 2012 Verification Survey – New and Repeat Deficiencies
Tag # 1A07 SSI Payments	Scope and Severity Rating: C	Completed
Tag # 1A08 Agency Case File	Scope and Severity Rating: B	Completed
Tag # 1A11 (CoP) Transportation P&P	Scope and Severity Rating: F	Completed
Tag # 1A11.1 (CoP) Transportation Training	Scope and Severity Rating: E	Completed
Tag # 1A20 DSP Training Documents	Scope and Severity Rating: E	Completed
Tag # 1A22 Staff Competence	Scope and Severity Rating: F	Completed
Tag # 1A25 (CoP) CCHS	Scope and Severity Rating: D	Completed
Tag # 1A27 (CoP) Late & Failure to Report	Scope and Severity Rating: E	Completed
Tag # 1A28.2 (CoP) Incident Mgt. System - Parent/Guardian Training	Scope and Severity Rating: E	Completed
Tag # 1A29 Complaints / Grievances - Acknowledgement	Scope and Severity Rating: B	Completed
Tag # 1A32 & 6L14 (CoP) ISP Implementation	Scope and Severity Rating: E	Completed
Tag # 1A36 Service Coordination	Scope and Severity Rating: B	Completed
Tag # 5I11.1 Reporting Requirements (CI Quarterly Report Components)	Scope and Severity Rating: B	Completed
Tag # 5I36 CA Reimbursement	Scope and Severity Rating: B	Completed
Tag # 5I44 AH Reimbursement	Scope and Severity Rating: A	Completed
Tag # 6L13 (CoP) - CL Healthcare Reqts.	Scope and Severity Rating: D	Completed
Tag # 6L14 Residential Case File	Scope and Severity Rating: E	Completed
Tag # 6L17.1 Reporting Requirements (CL Quarterly Report Components)	Scope and Severity Rating: C	Completed
Tag # 6L25 (CoP) Residential Health & Safety (Supported Living & Family Living)	Scope and Severity Rating: D	Completed
Tag # 6L25.1 (CoP) Residential Reqts. (Physical Environment - Supported Living & Family Living)	Scope and Severity Rating: D	Completed



SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

Date: August 17, 2012

To: Patrick Keptner, Executive Director
Provider: Tohatchi Area of Opportunity & Services, Inc.
Address: 161 South Catalpa Road
State/Zip: Gallup, New Mexico, 87301

E-mail Address: patkeptner@yahoo.com

CC: Johnnie Willeto Sr., Board Chair
Address: P.O. Box 21
State/Zip: Tohatchi, New Mexico, 87325

Board Chair: aetsitty-27@yahoo.com

Region: Northwest
Routine Survey: July 18 - 22, 2011
Verification Survey: February 28, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living (Supported Living) & Community Inclusion (Adult Habilitation, Community Access & Supported Employment)

Dear Mr. Keptner;

You have completed all the requirements per the Internal Review Committee (IRC).

The Plan of Correction process is now complete.

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

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

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

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



DIVISION OF HEALTH IMPROVEMENT • QUALITY MANAGEMENT BUREAU
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Sincerely,

Crystal Lopez-Beck

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

Q.13.01.D1703.NW.001.VS.09.230