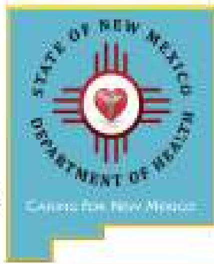
SUSANA MARTINEZ, GOVERNOR



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

|  |  |
|---|---|
| Date: | July 19, 2012 |
| To: | Pam Lillibridge, Chief Executive Officer |
| Provider: | Tresco, Inc. |
| Address: | 1800 Copper Loop |
| State/Zip: | Las Cruces, New Mexico 88004 |
| E-mail Address: | PLillibridge@trescomail.org |
| Region: | Southwest |
| Survey Date: | March 26 - 29, 2012 |
| Program Surveyed: | Developmental Disabilities Waiver |
| Service Surveyed: | Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment) |
| Survey Type: | Routine |
| Team Leader: | Mari Chavez, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau |
| Team Members: | Valerie V. Valdez, MS, Healthcare Program Manager, Division of Health Improvement/Quality Management Bureau; Jennifer Bruns, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Cynthia Nielsen, RN, Healthcare Surveyor, Division of Health Improvement/ Quality Management Bureau; Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/ Quality Management Bureau; Tony Fragua, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Erica Nilsen, BA, Division of Health Improvement/ Quality Management Bureau. |

Dear Ms. Lillibridge;

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

**Determination of Compliance:**

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

***Partial Compliance with Conditions of Participation***

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

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

**Plan of Correction:**
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

**Submission of your Plan of Correction:**
Please submit your agency's Plan of Correction in the space on the two right columns of the Report of Findings. *(See attachment "A" for additional guidance in completing the Plan of Correction)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator**
   **5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

Upon notification from QMB that your *Plan of Correction has been approved*, you must implement all remedies and corrective actions to come into compliance. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as your POC approval and all remedies must be completed within 45 business days of the receipt of this letter.

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Request for Informal Reconsideration of Findings (IRF):**
If you disagree with a finding of deficient practice, you have 10 business days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief
5301 Central Ave NE Suite #400
Albuquerque, NM 87108
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-699-9356 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

*Mari Chavez, BSW*

Mari Chavez, BSW
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

## Survey Process Employed:

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| Entrance Conference Date: | March 26, 2012 |
| Present: | **<u>Tresco, Inc.</u>**<br>Pam Lillibridge, Chief Executive Officer<br><br>**<u>DOH/DHI/QMB</u>**<br>Mari Chavez, BSW Team Lead/Healthcare Surveyor<br>Valerie V. Valdez, MS, Healthcare Program Manager |
| Exit Conference Date: | March 29, 2012 |
| Present: | **<u>Tresco, Inc.</u>**<br>Pam Lillibridge, Chief Executive Officer<br>Cheryl Young, Community Living Specialist Supervisor<br>Carol McClure, Community Living Specialist Supervisor<br>Dona Nelson, Community Living Specialist Supervisor<br>Waunita Brown, Community Living Specialist Supervisor<br>Suzanne Purcell, Community Living Specialist Supervisor<br>Gerald Lopez, Community Living Specialist Supervisor<br>Nicole Johnson, Quality Enhancement Systems Manager<br>Marilyn Kirby, Quality Advisor<br>MaryAnn Quesada, Employment Specialist<br>Rick Gutbrod, Billing Coordinator<br>Steve Adams, Assistant Vocational Service Manager<br>Al Sanchez, Vocational Services Manager<br>Maureen Gant, Program Support Manager<br>Milissa Fox, Employment Integration Specialist<br>Virginia Valenzuela, Program Support Administrative Assistant<br>Arlene Lindsey, Socorro Tresco (via telephone)<br><br>**<u>DOH/DHI/QMB</u>**<br>Mari Chavez, BSW, Team Lead/Healthcare Surveyor<br>Valerie V. Valdez, MS, Healthcare Program Manager<br>Jennifer Bruns, BSW, Healthcare Surveyor<br>Erica Nilsen, BA, Healthcare Surveyor<br>Cynthia Nielsen, RN, Healthcare Surveyor<br><br>**<u>DDSD - SW Regional Office</u>**<br>Scott Doan, Regional Director |

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| Total Homes Visited | Number: | 12 |
| ❖ Supported Homes Visited | Number: | 12 |
| Administrative Locations Visited | Number: | 2<br>▪ 1800 Copper Loop Las Cruces, New Mexico<br>▪ 211 Park St. Socorro, New Mexico |
| Total Sample Size | Number: | 24<br>8 - *Jackson* Class Members<br>16 - Non-*Jackson* Class Members<br>16 - Supported Living<br>6 - Independent Living<br>17 - Adult Habilitation |

2 - Community Access
17 - Supported Employment

| | | |
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| Persons Served Records Reviewed | Number: | 24 |
| Persons Served Interviewed | Number: | 12 |
| Persons Served Observed | Number: | 12 (2 individuals answers could not be understood by the surveyor; 4 individuals chose not to participate in interviews; 6 individuals were not available during the on-site survey. |
| Direct Support Personnel Interviewed | Number: | 42 |
| Direct Support Personnel Records Reviewed | Number: | 189 |
| Service Coordinator Records Reviewed | Number: | 6 |

Administrative Files Reviewed

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

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

**Attachment A**

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

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

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

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

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

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

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

***Instructions for Completing Agency POC:***

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

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

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

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and

sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and

5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

*The following details should be considered when developing your POC:*

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

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

***Completion Dates***

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

***Initial Submission of the Plan of Correction Requirements***

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the QMB POC Coordinator at 505-699-9356 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to Crystal Lopez-Beck, POC Coordinator in any of the following ways:
    a. Electronically at crystal.lopez-beck@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approve” or “denied.”

   a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

***POC Document Submission Requirements***

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

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

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

## QMB Determinations of Compliance

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

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

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

- "Non-Compliant with Conditions of Participation":
  The QMB determination of "Non-Compliance with Conditions of Participation," indicates a provider is significantly out of compliance with Conditions of Participation and/or has:
  - 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.

**Attachment C**

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

**Introduction:**

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

**Instructions:**

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

**The following limitations apply to the IRF process:**

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

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

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

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

**Agency:** **Tresco, Inc. - Southwest Region**
Program: Developmental Disabilities Waiver
Service: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Monitoring Type: Routine Survey
**Date of Survey:** **March 26 - 29, 2012**

| Standard of Care | *Deficiencies* | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
|---|---|---|---|
| ***CMS Assurance – Service Plans: ISP Implementation –*** *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.* | | | |
| **Tag # 1A08 Agency Case File** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br>**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: | Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 24 individuals.<br><br>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:<br><br>• **Current Emergency & Personal Identification Information**<br>° Did not contain Health Plan Information (#21)<br><br>• ISP Signature Page (#5 & 13)<br><br>• Documentation of Guardianship/Power of Attorney (#1)<br><br>• **Dental Exam**<br>° Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of current exam was found | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| (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;<br>(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);<br>(3) Progress notes and other service delivery documentation;<br>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;<br>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;<br>(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<br>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.<br>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:<br>(a) Complete file for the past 12 months;<br>(b) ISP and quarterly reports from the current and prior ISP year;<br>(c) Intake information from original admission to services; and<br>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training | • **Vision Exam**<br>• Individual #7 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of current exam was found.<br><br>• **Cholesterol & Blood Glucose**<br>◦ Individual #10 - As indicated by collateral documentation reviewed, lab work was ordered on 10/29/11. No evidence of lab results was found. | | |

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| School or Ft. Stanton Hospital.<br><br>**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.<br><br>B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. | | | |

| Tag # 1A08.1 Agency Case File - Progress Notes | Standard Level Deficiency | | |
|---|---|---|---|
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br>**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:<br><br>(3) Progress notes and other service delivery documentation; | Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 2 of 24 Individuals.<br><br>**Supported Living Progress Notes/Daily Contact Logs**<br>• Individual #1 - None found for 2/26/2012<br><br>• Individual #4 - None found for 2/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 & 29/2012. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>______________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

| Tag # 1A32 & 6L14 ISP Implementation | Standard Level Deficiency | | |
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| **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.<br><br>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.<br><br>D. The intent is to provide choice and obtain opportunities for individuals to live, work and | 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 3 of 24 individuals.<br><br>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:<br><br>***Administrative Files Reviewed:***<br><br>**Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #21<br>• None found regarding: Fun Outcome, "…will take a mini vacation to a new place once a year." for 11/2011, 12/2011 & 1/2012.<br><br>• None found regarding: Live Outcome, "…will use visual schedule each morning with only one prompt per task." for 12/2011.<br><br>**Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**<br><br>• Individual #1 - None found for 2/2012.<br><br>***Residential Files Reviewed:***<br><br>**Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:<br><br>Individual #23<br>• Per Live Outcome; Actions Steps for, "… will | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br><br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.<br>[05/03/94; 01/15/97; Recompiled 10/31/01] | feed her fish with hand over hand assistance," is to be completed one time daily. Evidence found indicated it was not being completed at the required frequency indicated in the ISP for 3/1 & 2, 2012. | | |

| Tag # 5I22 SE Agency Case File | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS**<br>**D. Provider Agency Requirements**<br>(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.<br><br>(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:<br><br>(a) Quarterly progress reports;<br><br>(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;<br><br>(c) Career development plan as incorporated in the ISP; a career development plan consists of | Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 17 individuals receiving Supported Employment Services.<br><br>The following were not found, incomplete and/or not current:<br><br>• Vocational Assessment (#17) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and<br><br>(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.<br><br>New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy<br>**Policy Title: Vocational Assessment Profile Policy Eff July 16, 2008**<br>**I. PURPOSE**<br>The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.<br><br>**II. POLICY STATEMENT**<br>Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures. | | | |

| Tag # 6L14 Residential Case File | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**<br><br>**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:<br>(1) Complete and current ISP and all supplemental plans specific to the individual;<br>(2) Complete and current Health Assessment Tool;<br>(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;<br>(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);<br>(5) Data collected to document ISP Action Plan implementation | Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 12 of 16 Individuals receiving Supported Living Services.<br><br>The following was not found, incomplete and/or not current:<br><br>• **Current Emergency & Personal Identification Information**<br>° Did not contain name and phone numbers of relatives, or guardian or conservator Information (#2)<br>° Did not contain Individual's Current Address (#3, 12 & 23)<br>° Did not contain Individual's Phone Number Information (#3)<br>° Did not contain Individual's Health Plan Information (#24)<br><br>• Positive Behavioral Plan (#17, 18 & 24)<br>• Positive Behavioral Crisis Plan (#3, 14, 17, 18, 23 & 24)<br>• Speech Therapy Plan (#1 & 24)<br>• Occupational Therapy Plan (#1, 17 & 24)<br>• **Special Health Care Needs**<br>° CARMP (#3)<br>• **Health Care Plans**<br>° Aspiration (#3 & 14)<br>° Weight/Body Mass Index (#3 &18) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>________________________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| (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;<br>(7) Physician's or qualified health care providers written orders;<br>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);<br>(9) Medication Administration Record (MAR) for the past three (3) months which includes:<br>(a) The name of the individual;<br>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;<br>(c) Diagnosis for which the medication is prescribed;<br>(d) Dosage, frequency and method/route of delivery;<br>(e) Times and dates of delivery;<br>(f) Initials of person administering or assisting with medication; and<br>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.<br>(h) For PRN medication an explanation for the use of the PRN must include:<br>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and<br>(ii) Documentation of the effectiveness/result of the PRN delivered.<br>(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 | ° Constipation (#3)<br>° Oral Care (#3)<br>° Seizures (#1)<br>° Skin Integrity (#18)<br><br>• **Crisis Plan/Medical Emergency Response Plans**<br>° Allergies (#5)<br>° Weight/Body Mass Index (#2)<br>° Falls (#16, 17 & 18)<br>° Gastrointestinal (#16)<br><br>• **Progress Notes/Daily Contacts Logs:**<br>° Individual #1 - None found for 3/1 – 24, 2012.<br><br>° Individual #2 - None found for 3/1 – 24, 2012.<br><br>° Individual #3 - None found for 3/1 – 24, 2012.<br><br>° Individual #5 - None found for 3/1 – 24, 2012.<br><br>° Individual #12 - None found for 3/1 – 24, 2012.<br><br>° Individual #13 - None found for 3/1 – 24, 2012.<br><br>° Individual #14 - None found for 3/1 – 24, 2012.<br><br>° Individual #15 - None found for 3/1 – 24, 2012.<br><br>° Individual #16 - None found for 3/1 – 24, 2012. | | |

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| copy must be placed in the agency file on a weekly basis.<br>(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<br>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam. | ° Individual #17 - None found for 3/1 – 24, 2012.<br><br>° Individual #18 - None found for 3/1 – 24, 2012.<br><br>° Individual #23 - None found for 3/1 – 24, 2012. | | |

| Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports) | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**<br><br>**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:<br><br>(1) Timely completion of relevant activities from ISP Action Plans<br><br>(2) Progress towards desired outcomes in the ISP accomplished during the quarter;<br><br>(3) Significant changes in routine or staffing;<br><br>(4) Unusual or significant life events;<br><br>(5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and<br><br>(6) Data reports as determined by IDT members. | Based on record review, the Agency failed to complete written quarterly status reports for 2 of 22 individuals receiving Community Living Services.<br><br>**Supported Living Quarterly Reports:**<br>• Individual #17 – No progress noted for 3/2011 - 6/2011 on Live Outcome, "…will create note cards with his photo collections to sell, donate, give as gifts."<br><br>**Support Living Annual Assessment**<br>• Individual #20 - None found for 11/2010 – 11/2011 | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

| Standard of Care | *Deficiencies* | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***CMS Assurance – Qualified Providers –** The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.* | | | |
| **Tag # 1A11.1 Transportation Training** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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…<br><br>**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007<br><br>**II. POLICY STATEMENTS:**<br>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:<br>1. Operating a fire extinguisher<br>2. Proper lifting procedures<br>3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat)<br>4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines | Based on record review and interview, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 1 of 189 Direct Support Personnel.<br><br>No documented evidence was found of the following required training:<br><br>• Transportation (DSP #234) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)<br>5. Operating wheelchair lifts (if applicable to the staff's role)<br>6. Wheelchair tie-down procedures (if applicable to the staff's role)<br>7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) | | | |

| Tag # 1A20 Direct Support Personnel Training | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.<br>**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:<br>(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<br>(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.<br><br>**Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for** | Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 8 of 189 Direct Support Personnel.<br><br>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:<br><br>• Person-Centered Planning (1-Day) (DSP #106)<br><br>• First Aid (DSP #234)<br><br>• CPR (DSP #76, 201 & 234)<br><br>• Assisting With Medication Delivery (DSP #71, 123, 145 & 185) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

| **Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:**<br>A. Individuals shall receive services from competent and qualified staff.<br>B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.<br>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.<br>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.<br>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.<br>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.<br>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.<br>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.<br>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service. | | | |
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| Tag # 1A22 Agency Personnel Competency | Condition of Participation Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.<br>**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:<br>(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;<br><br>(2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP;<br><br>(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 | After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.<br><br>Based on interview, the Agency failed to ensure that training competencies were met for 13 of 42 Direct Support Personnel.<br><br>**When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:**<br>• DSP #97 stated, “Help her read and speak, she’s very timid. I really don’t know why she needs a BT.” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #19)<br><br>**When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:**<br>• DSP #66 stated, “Ya, I think she does. She has just been placed at our agency.” As indicated by documentation review the individual does not require a Positive Behavioral Crisis Plan. (Individual #7)<br><br>• DSP #179 stated, “I don’t think so.” According to the Individual Specific Training Section of the ISP, the individual requires Positive Behavioral Crisis Plan. (Individual #3)<br><br>• DSP #186 stated, “No, not a crisis plan.” According to the Individual Specific Training Section of the ISP, the individual requires | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>---<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| individual;<br><br>(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and<br><br>(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.<br><br>(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:<br>(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;<br>(b) Staff who do not wish to use his or her Social Security Number may request an alternative tracking number; and<br>(c) Quarterly personnel update reports sent to DDSD Statewide Training Database to reflect new hires, terminations, inter-provider Agency position changes, and name changes.<br><br>**Department of Health (DOH) Developmental** | Positive Behavioral Crisis Plan. (Individual #14)<br><br>• DSP #102 stated, "I don't believe so." According to the Individual Specific Training Section of the ISP, the individual requires Positive Behavioral Crisis Plan. (Individual #14)<br><br>**When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:**<br>• DSP #56 stated, "Yes, for aspiration, oral hygiene and nutrition." As indicated by the Electronic Comprehensive Health Assessment Tool the Individual also requires Health Care Plans for constipation & falls. (Individual #16)<br><br>• DSP #66 stated, "Not sure, she's on a 14 day placement and mom took care of all that." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for oral care and falls. (Individual #7)<br><br>• DSP #66 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for seizures. (Individual #8)<br><br>• DSP #74 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for weight/BMI. (Individual #10)<br><br>• DSP #90 stated, "Just for picking at her skin." As indicated by the Agency file, the Individual requires Health Care Plans for weight/BMI, | | |

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| **Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:**<br>A. Individuals shall receive services from competent and qualified staff. | oral care, aspiration & constipation. (Individual #3)<br><br>• DSP #95 stated, "Probably Autism and Hypothyroidism." According to the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for oral care & constipation. (Individual #5)<br><br>• DSP #97 stated, "Not that I know of." As indicated by the Electronic Comprehensive Health Assessment Tool the Individual requires Health Care Plans for seizures, diabetes & constipation. (Individual #19)<br><br>• DSP #126 stated, "Just diabetes." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for weight/BMI and constipation. (Individual #9)<br><br>• DSP #144 stated, "He has low fat-BMI and Seizure Health Care Plan." As indicated by the Electronic Comprehensive Health Assessment Tool the Individual also requires a Health Care Plan for falls. (Individual #17)<br><br>**When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:**<br><br>• DSP #56 stated, "Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for falls. (Individual #16)<br><br>• DSP #66 stated, "No, her mom took care of all that." As indicated by the Electronic | | |

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| | Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for falls. (Individual #7)<br><br>• DSP #66 stated, "No, mom takes care of medical." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for seizures. (Individual #8)<br><br>• DSP #126 stated, "No, she doesn't." As indicated by the IST section of the ISP, the Individual requires a Crisis Plan/Medical Emergency Response Plan for diabetes. (Individual #9)<br><br>• DSP #144 stated, "No crisis plans." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for seizures and falls. (Individual #17)<br><br>• DSP #186 stated, "She has constipation and one for aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Crisis Plans/Medical Emergency Response Plan for falls. (Individual #14)<br><br>• DSP #234 reported plans on Aspiration and Seizures. As indicated by the Electronic Comprehensive Health Assessment Tool, the individual requires a Medical Emergency Response Plan for a Neuro device. (Individual #12)<br><br>**When DSP were asked if the Individual had a Seizure Disorder, the following was reported:**<br><br>• DSP #66 stated, "No, I wasn't aware till I read | | |

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| | his book. He never has them. We just found out today he gets seizures." According to the ISP, the individual has a diagnosis of seizures. (Individual #8)<br><br>**When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:**<br><br>• DSP #132 stated, "No, he doesn't." Per Therap the individual has an allergy to Cefotan. (Individual #2)<br><br>• DSP #234 stated, "No." Per Therap the individual has an allergy to Lindane, Boniva and silk tape. (Individual #12)<br><br>**When DSP were asked to describe what medications are prescribed for the individual, the following was reported:**<br><br>• DSP #166 stated, "We don't assist her, we don't know." DSP was unable to reference medications nor the MARs as the medication and information are locked and DSP did not have access. (Individual #23) | | |

| Tag # 1A28.1 Incident Mgt. System - Personnel Training | Standard Level Deficiency | | |
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| **NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:**<br>**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.<br>**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.<br>**Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007**<br>**II. POLICY STATEMENTS:**<br>A. Individuals shall receive services from | Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 2 of 195 Agency Personnel.<br><br>**Direct Support Personnel (DSP):**<br>• Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#234)<br><br>**When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers' Property, the following was reported:**<br><br>• DSP #97 stated, "I can't think right now." Staff was not able to identify the two State Agencies as APS & DHI. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| competent and qualified staff.<br>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. | | | |

| Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training | Standard Level Deficiency | | |
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| **NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:**<br>**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.<br><br>**E. Consumer and Guardian Orientation Packet:** Consumers, family members and legal guardians shall be made aware of and have available immediate accessibility to the licensed health care facility and community based service provider incident reporting processes. The licensed health care facility and community based service provider shall provide consumers, family members or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect or misappropriation. The licensed health care facility and community based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member or legal guardian shall sign this at the time of orientation. | Based on record review, the Agency 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 1 of 24 individuals.<br><br>• Parent/Guardian Incident Management Training (Abuse, Neglect & Misappropriation of Consumers' Property) (#21) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

| Tag # 1A36 Service Coordination Requirements | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.<br><br>**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:<br><br>(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<br><br>**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 | Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 1 of 6 Service Coordinators.<br><br>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:<br><br>• ISP Critique (SC #233)<br><br>• Sexuality for People with Developmental Disabilities (SC #233) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| community service provider agency<br><br>**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 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:<br><br>(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;<br>(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;<br>(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;<br>(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 # 1A37 Individual Specific Training | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.<br><br>**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:<br>(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.<br><br>**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:**<br>**A.** Individuals shall receive services from competent and qualified staff.<br>**B.** Staff shall complete individual-specific (formerly known as "Addendum B") training | Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 1 of 195 Agency Personnel.<br><br>Review of personnel records found no evidence of the following:<br><br>**Direct Support Personnel (DSP):**<br><br>• Individual Specific Training (#234) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>________________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

| requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. | | | |
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| Standard of Care | *Deficiencies* | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| ***CMS Assurance – Health and Welfare –*** *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.* | | | |
| **Tag # 1A03 CQI System** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS**<br>**I. Continuous Quality Management System:** Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider's service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:<br>(1) Individual access to needed services and supports;<br>(2) Effectiveness and timeliness of implementation of Individualized Service Plans;<br>(3) Trends in achievement of individual outcomes in the Individual Service Plans;<br>(4) Trends in medication and medical incidents leading to adverse health | Based on record review, the Agency failed to implement their Continuous Quality Management System as required.<br><br>Review of the Agency's Quality Assurance/Improvement Plan found it to be well written and well intended, nevertheless, the evidence found during the routine survey on March 26 – 29, 2012 indicate the Agency had substantial deficiencies in each area of the CMS Assurances. The Agency was cited with a total of 26 tags, therefore indicating the agency has failed to implement their own plan.<br><br>In addition, review of collateral documentation indicated the agency has failed to address and/or implement improvement actions as they relate to:<br><br>• Trends in medication and medical incidents leading to adverse health events;<br><br>• Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;<br><br>• Internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues, specifically in the area of late reporting and failure to report. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| events;<br>(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;<br>(6) Quality and completeness documentation; and<br>(7) Trends in individual and guardian satisfaction.<br><br>**7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:**<br>**E. Quality Improvement System for Community Based Service Providers:** The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:<br><br>**(1)** community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;<br>**(2)** community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;<br>**(4)** community based service providers | | | |

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| providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues. | | | |

| Tag # 1A09 Medication Delivery (MAR) - Routine Medication | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br>**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.<br><br>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:<br>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;<br>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; | Medication Administration Records (MAR) were reviewed for the months of January, February & March of 2012.<br><br>Based on record review, 6 of 24 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:<br><br>Individual #1<br>January 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Citrucel (1 time daily)<br><br>February 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Citrucel (1 time daily)<br><br>Individual #3<br>January 2012<br>• As indicated by the Medication Administration Records the individual is to take Fluvoxamine Maleate 150 mg (1 time daily). According to the Physician's orders, Fluvoxamine Maleate 100 mg is to be taken 1 time daily, Medication Administration Record & Physician's order do not match.<br><br>February 2012<br>Physician's orders indicated the following medication were to be given. The following Medications were not documented on the Medication Administration Records:<br>• Fluvoxamine Maleate 100 mg (1 time daily) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>__________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| (c) Initials of the individual administering or assisting with the medication;<br>(d) Explanation of any medication irregularity;<br>(e) Documentation of any allergic reaction or adverse medication effect; and<br>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.<br>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;<br>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;<br>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;<br><br>**NMAC 16.19.11.8 MINIMUM STANDARDS:**<br>A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:<br><br>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include:<br>(i) Name of resident;<br>(ii) Date given; | March 2012<br>• As indicated by the Medication Administration Records the individual is to take Fluvoxamine Maleate 150 mg (1 time daily). According to the Physician's order, Fluvoxamine Maleate 100 mg is to be taken 1 time daily, Medication Administration Record & Physician's Order do not match.<br><br>Individual #12<br>March 2012<br>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:<br>• Peridex Oral Rinse (2 times daily) – Blank 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 & 26 (8 AM)<br><br>• Peridex Oral Rinse (2 times daily) – Blank 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24 & 25 (8 PM)<br><br>Individual #20<br>February 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Apri Birth Control (1 time daily)<br><br>• Ciclopirox Cream 6.6 ml (1 time daily)<br><br>• Desitin Cream (apply after bath)<br><br>• Hydrocortisone 28.4 gm (1 time daily)<br><br>• Hydroxyzine 100 mg (1 time daily) | | |

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| (iii) Drug product name;<br>(iv) Dosage and form;<br>(v) Strength of drug;<br>(vi) Route of administration;<br>(vii) How often medication is to be taken;<br>(viii) Time taken and staff initials;<br>(ix) Dates when the medication is discontinued or changed;<br>(x) The name and initials of all staff administering medications.<br><br>**Model Custodial Procedure Manual**<br>***D. Administration of Drugs***<br>Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.<br>Document the practitioner's order authorizing the self-administration of medications.<br><br>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:<br>➢ symptoms that indicate the use of the medication,<br>➢ exact dosage to be used, and<br>➢ the exact amount to be used in a 24 hour period. | • Levothyroxine 50mcg (1 time daily)<br><br>• Loratadine 10mg (1 time daily)<br><br>• Magnesium Oxide (2 times daily)<br><br>• Multivitamin 1000mg (1 time daily)<br><br>• Nystantin (apply after bath)<br><br>• Celexa 40mg (1 time daily)<br><br>• Clomipramine 75mg (1 time daily)<br><br>• Cogentin 1mg (time daily)<br><br>• Haloperidol .5mg (2 times daily)<br><br>• Pilosec 20mg (1 time daily)<br><br>• Probiotic Lactobacillus (2 times daily)<br><br>Individual #22<br>January 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Allegra 60mg (2 times daily)<br><br>• Fosamax 70mg (1 time daily)<br><br>• Gemfibrozil 600mg (2 times daily)<br><br>• Hydroxyzine 25mg (3 times daily)<br><br>• Levothyroxine 100mcg (1 time daily)<br><br>• Lotrisone Cream 1%/.05% (2 times daily)<br><br>• Metformin 500mg (2 times daily) | | |

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| | • Ultram 50mg (3 times daily)<br>• Vitamin D 400 unit (1 time daily)<br>• Vitamin B12 1000mcg (1 time daily)<br>• Trazadone 200mg (1 time daily)<br>• Zoloft 200mg (1 time daily)<br><br>February 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br><br>• Allegra 60mg (2 times daily)<br>• Fosamax 70mg (1 time daily)<br>• Gemfibrozil 600 mg (2 times daily)<br>• Hydroxyzine 25mg (3 times daily)<br>• Levothyroxine 100mcg  (1 time daily)<br>• Metformin 500mg (2 times daily)<br>• Ultram 50mg (3 times daily)<br>• Vitamin D 400 unit (1 time daily)<br>• Vitamin B12 1000mcg (1 time daily)<br>• Trazadone 200mg (1 time daily)<br>• Zoloft 200mg (1 time daily)<br><br>Individual #23<br>January 2012 | | |

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| | Medication Administration Records did not contain the strength of the medication which is to be given:<br>• Dilantin (2 times daily)<br><br>• Metoclopramide (3 times daily)<br><br>Medication Administration Records did not contain the correct route of administration for the following medications. MAR states the following medication is to be given orally. According to Therap and ISP the individual receives all food and medications via G-tube:<br>• Dilantin (2 times daily) | | |

| Tag # 1A09.1 Medication Delivery - PRN Medication | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br>**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.<br><br>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:<br>(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;<br>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; | Based on record review, the Agency failed to maintain PRN Medication Administration Records which contained all elements required by standard for 4 of 24 Individuals.<br><br>Individual #1<br>February 2012<br>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:<br>• Triazolam .25 mg (PRN)<br><br>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:<br>• Triazolam .25 mg (PRN) 2/3, 6, 10, & 24 (given 1 time daily)<br><br>• Triple Antibiotic Ointment (PRN) 2/3, 10 & 24 (given 1 time daily)<br><br>Individual #6<br>January 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Metamucil (PRN)<br><br>February 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Metamucil (PRN)<br><br>Individual #12<br>March 2012<br>No effectiveness was noted on the Medication Administration Record for the | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>__________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| (c) Initials of the individual administering or assisting with the medication;<br>(d) Explanation of any medication irregularity;<br>(e) Documentation of any allergic reaction or adverse medication effect; and<br>(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.<br><br>(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;<br><br>(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;<br><br>(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;<br><br>**NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:**<br>(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: | following PRN medication:<br>• Ativan 2 mg – PRN – 3/14 & 16 (given 1 time) & 3/15 (given 2 times)<br><br>Medication Administration Record document did not contain staff's initial, used to document administered or assisted delivery of each dose for the following medications:<br>• Ativan 2 mg – PRN – 3/15/2012 (10AM)<br><br>Individual #23<br>January 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Acetometephin 500mg (PRN)<br><br>February 2012<br>Medication Administration Records did not contain the route of administration for the following medications:<br>• Acetometephin 500mg (PRN) | | |

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| (i) Name of resident;<br>(ii) Date given;<br>(iii) Drug product name;<br>(iv) Dosage and form;<br>(v) Strength of drug;<br>(vi) Route of administration;<br>(vii) How often medication is to be taken;<br>(viii) Time taken and staff initials;<br>(ix) Dates when the medication is discontinued or changed;<br>(x) The name and initials of all staff administering medications.<br><br>**Model Custodial Procedure Manual**<br>***D. Administration of Drugs***<br>Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.<br>Document the practitioner's order authorizing the self-administration of medications.<br><br>All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:<br>➢ symptoms that indicate the use of the medication,<br>➢ exact dosage to be used, and<br>➢ the exact amount to be used in a 24 hour period.<br><br>**Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006**<br>**F. PRN Medication**<br>3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure | | | |

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| that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.<br><br>4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).<br><br>**H. Agency Nurse Monitoring**<br>1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. | | | |

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| **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006**<br>C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).<br><br>a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff.<br><br>4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). | | | |

| Tag # 1A15.2 & 5I09 - Healthcare Documentation | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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.<br><br>**Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment activities**<br>(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:<br>(i) Community living services provider agency;<br>(ii) Private duty nursing provider agency;<br>(iii) Adult habilitation provider agency;<br>(iv) Community access provider agency; and<br>(v) Supported employment provider agency.<br>(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 | Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 5 of 24 individuals.<br><br>The following were not found, incomplete and/or not current:<br><br>• Comprehensive Aspiration Risk Management Plan (#14)<br><br>• **Special Healthcare Needs:**<br>• *Nutritional Plan*<br>° Individual #20 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.<br><br>• **Health Care Plans**<br>• *Weight/Body Mass Index*<br>Individual #20 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.<br><br>• *Constipation*<br>Individual #9 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.<br><br>• **Crisis Plans/Medical Emergency Response Plans**<br>• *Allergies*<br>° Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.<br><br>• *Falls* | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>______________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| 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.<br>(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.<br>(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).<br>(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, | ° Individual #7 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found. | | |

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| method in which temperature taken); *assessment* of the clinical status, and *plan* of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.<br>**(2) Health related plans**<br>(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.<br>(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.<br>(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.<br>(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.<br>(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):<br>(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 | | | |

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| 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.<br>(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.<br>(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.<br>(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.<br>(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.<br>(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.<br>(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. | | | |

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| (h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.<br>**(4) General Nursing Documentation**<br>(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.<br>(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.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS**<br>**B. IDT Coordination**<br>(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<br><br>(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. | | | |

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| **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010**<br><br>F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:<br>1. A brief, simple description of the condition or illness.<br>2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.<br>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).<br>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.<br>5. Emergency contacts with phone numbers.<br>6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located. | | | |

| Tag # 1A27 Incident Mgt Late & Failure to Report | Standard Level Deficiency | | |
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| **7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:**<br>**A. Duty To Report:**<br>**(1)** All community based service providers shall immediately report abuse, neglect or misappropriation of property to the adult protective services division.<br>**(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:<br>**(a)** an environmental hazardous condition, which creates an immediate threat to life or health; or<br>**(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.<br>**(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.<br>**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 | 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 12 of 32 individuals.<br><br>Individual #15<br>• Incident date 2/21/11. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #16<br>• Incident date 1/8/2011. Allegation was Abuse. Incident report was received 1/18/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #17<br>• Incident date 2/21/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #24<br>• Incident date 3/9/2011. Allegation was Neglect. Incident report was received 3/10/2011. Failure to Report. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>• Incident date 10/10/2011. Allegation was Neglect. Incident report was received | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>________________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| instructions for the completion and filing are available at the division's website, http://dhi.health.state.nm.us/elibrary/ironline/ir.php or may be obtained from the department by calling the toll free number. | 10/12/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #25<br>• Incident date 3/23/2011. Allegation was Emergency Services. Incident report was received 3/25/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #26<br>• Incident date 2/21/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #27<br>• Incident date 2/21/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #28<br>• Incident date 2/21/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #29<br>• Incident date 2/21/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #30 | | |

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| | • Incident date 2/21/2011. Allegation was Neglect. Incident report was received 4/20/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #31<br>• Incident date 10/10/2011. Allegation was Neglect. Incident report was received 10/13/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #32<br>• Incident date 10/10/2011. Allegation was Neglect. Incident report was received 10/13/2011. Late Reporting. IMB Late & Failure Report indicated incident of Neglect was "Confirmed." | | |

| Tag # 1A31 Client Rights/Human Rights | Standard Level Deficiency | | |
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| **7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:**<br>A. A service provider shall not restrict or limit a client's rights except:<br>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or<br>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or<br>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].<br><br>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.<br><br>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]<br><br>**Long Term Services Division**<br>**Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** | Based on record review, the Agency failed to ensure the rights of Individuals was not restricted or limited for 3 of 24 Individuals.<br><br>A review of Agency Individual files found no documentation of Positive Behavior Plans and/or Positive Behavior Crisis Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (Individual #15, 16 & 20)<br><br>No quarterly Human Rights Approval found regarding following:<br><br>• Physical Restraint (MANDT) - (Individual #15, 16 & 20)<br><br>• Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #16) | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br><br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.<br><br>Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:<br>• Aversive Intervention Prohibitions<br>• Psychotropic Medications Use<br>• Behavioral Support Service Provision.<br><br>A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.<br><br>**A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS**<br>Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.<br><br>2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.<br><br>3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. | | | |

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| **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure Eff Date: November 1, 2006**<br>**B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). | | | |

| Tag # 1A33 Board of Pharmacy - Med Storage | Standard Level Deficiency | | |
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| **New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual**<br>**E. Medication Storage:**<br>1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.<br>2. Drugs to be taken by mouth will be separate from all other dosage forms.<br>3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.<br>4. Separate compartments are required for each resident's medication.<br>5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.<br>6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.<br><br>**8. References**<br>A. Adequate drug references shall be available for facility staff<br><br>**H. Controlled Substances (Perpetual Count Requirement)**<br>1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, | Based on record review and observation, the Agency failed to ensure proper storage of medication for 1 of 24 individuals.<br><br>Observation included:<br>Individual #12<br>• Betadin 7.5% lotion was not kept separate from medications to be administered orally. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>__________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| indicating the following information:<br>a. date<br>b. time administered<br>c. name of patient<br>d. dose<br>e. practitioner's name<br>f. signature of person administering or assisting with the administration the dose<br>g. balance of controlled substance remaining. | | | |

| Tag # 6L13 Community Living Healthcare Reqts. | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING**<br>**G. Health Care Requirements for Community Living Services**.<br>(1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first.<br>(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.<br>(3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:<br>(a)Provision of health care oversight consistent with these Standards as | 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 7 of 22 individuals receiving Community Living Services.<br><br>The following was not found, incomplete and/or not current:<br>° **Dental Exam**<br>° Individual #24 - As indicated by collateral documentation reviewed, the exam was completed on 8/24/2010. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found.<br><br>• **Vision Exam**<br>• Individual #8 - As indicated by the DDSD file matrix Vision Exams are to be conducted annually. No evidence of exam was found.<br><br>• Individual #16 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.<br><br>• Individual #20 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.<br><br>• **Auditory Exam**<br>• Individual #6 - As indicated by collateral documentation reviewed, exam was completed on 9/1/2009. Follow-up was to be completed in 12 months. No evidence of follow-up found. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>______________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services.<br>b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.<br>(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.<br>(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.<br>(5) That the physical property and grounds are free of hazards to the individual's health and safety.<br>(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:<br>(a) The individual has a primary licensed physician;<br>(b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;<br>(c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;<br>(d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and<br>(e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine). | • **Psychological Assessment**<br>• Individual #20 - As indicated by collateral documentation reviewed, exam was ordered at annual physical on 9/13/2011. No evidence of follow-up found.<br><br>• **Pap Smear Exam**<br>• Individual #9 - As indicated by collateral documentation reviewed, a Pap smear was ordered during the annual exam on 9/6/2011. No evidence of exam found.<br><br>• **Mammogram Exam**<br>• Individual #9 - As indicated by collateral documentation reviewed, a Mammogram was ordered during the annual exam on 9/6/2011. No evidence of exam found.<br><br>• **Bone Density Exam**<br>• Individual #9 - As indicated by collateral documentation reviewed, a Bone Density Scan was ordered during the annual exam on 9/6/2011. No evidence of exam found.<br><br>• **Blood Levels**<br>• Individual #21 - As indicated by collateral documentation reviewed, lab work was ordered on 11/10/2011. No evidence of lab work found. | | |

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| **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.<br><br>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 # 6L25 Residential Health & Safety (Supported Living & Family Living) | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**<br>**L. Residence Requirements for Family Living Services and Supported Living Services**<br>(1) Supported Living Services and Family Living Services providers shall assure that each individual's residence has:<br>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;<br>(b) General-purpose first aid kit;<br>(c) When applicable due to an individual's health status, a blood borne pathogens kit;<br>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;<br>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;<br>(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;<br>(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<br>(h) Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence | Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 6 of 12 Supported Living residences.<br><br>The following items were not found, not functioning or incomplete:<br><br>**Supported Living Requirements:**<br><br>• General-purpose first aid kit (#12)<br><br>• 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 (#12, 16, 20, 21 & 23)<br><br>• 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 (#12, 16, 18 & 23)<br><br>*Note: Individuals #1 & 14 share a residence; Individuals 5 & 13 share a residence; Individuals #13 & 23; Individuals #20 & 21 share a residence.* | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>______________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

| unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. | | | |
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| Standard of Care | *Deficiencies* | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due |
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| **CMS Assurance – Financial Accountability –** *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver*. | | | |
| **Tag # 5I25 Supported Employment Reimbursement** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**<br>**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.<br>**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:<br>(1) Date, start and end time of each service encounter or other billable service interval;<br>(2) A description of what occurred during the encounter or service interval; and<br>(3) The signature or authenticated name of staff providing the service.<br><br>**MAD-MR: 03-59 Eff 1/1/2004**<br>**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** | Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 2 of 17 individuals<br><br>Individual #4<br>December 2011<br>• The Agency billed 4 units of Supported Employment (T2019) on 12/7/2011. Documentation received accounted for 2 units.<br><br>• The Agency billed 4 units of Supported Employment (T2019) on 12/14/2011. Documentation received accounted for 2 units.<br><br>• The Agency billed 4 units of Supported Employment (T2019) on 12/21/2011. Documentation received accounted for 2 units.<br><br>• The Agency billed 4 units of Supported Employment (T2019) on 12/28/2011. Documentation received accounted for 2 units.<br><br>Individual #13<br>December 2011<br>• The Agency billed 1.25 units of Supported Employment (T2013) on 12/1/2011. Documentation received accounted for 1 | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>---<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| 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.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS**<br>**E. Reimbursement**<br>(1) Billable Unit:<br><br>(a) Job Development is a single flat fee unit per ISP year payable once an individual is placed in a job.<br><br>(b) The **billable unit for Individual Supported Employment** is one hour with a maximum of four hours a month. The Individual Supported Employment hourly rate is for face-to-face time which is supported by non face-to-face activities as specified in the ISP and the performance based contract as negotiated annually with the provider agency. Individual Supported Employment is a minimum of one unit per month. If an individual needs less then one hour of face-to-face service per month the IDT Members shall consider whether Supported Employment Services need to be continued. Examples of non face-to-face services include:<br>(i) Researching potential employers via telephone, Internet, or visits;<br>(ii) Writing, printing, mailing, copying, emailing applications, resume, references and corresponding documents;<br>(iii) Arranging appointments for job tours, | unit. | | |

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| interviews, and job trials;<br>(iv) Documenting job search and acquisition progress;<br>(v) Contacting employer, supervisor, co-workers and other IDT team members to assess individual's progress, needs and satisfaction; and<br>(vi) Meetings with individual surrounding job development or retention not at the employer's site.<br>(c) Intensive Supported Employment services are intended for individuals who need one-to-one, face-to-face support for 32 or more hours per month. The billable unit is one hour.<br><br>(d) Group Supported Employment is a fifteen-minute unit.<br><br>(e) Self-employment is a fifteen minute unit.<br><br>(4) Billable Activities include:<br><br>(a) Activities conducted within the scope of services;<br><br>(b) Job development and related activities for up to ninety (90) calendar days) that result in employment of the individual for at least thirty (30) calendar days; and<br><br>(c) Job development services shall not exceed ninety (90) calendar days, without written approval from the DDSD Regional Office. | | | |

| Tag # 5I36 Community Access Reimbursement | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**<br>**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.<br>**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:<br>(1) Date, start and end time of each service encounter or other billable service interval;<br>(2) A description of what occurred during the encounter or service interval; and<br>(3) The signature or authenticated name of staff providing the service.<br><br>**MAD-MR: 03-59 Eff 1/1/2004**<br>**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**<br>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 | Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Community Access Services for 1 of 2 individuals.<br><br>Individual #24<br>December 2011<br>• The Agency billed 23 units of Community Access (H2021) from on 12/22/2011. Documentation received accounted for 22 units.<br><br>January 2012<br>• The Agency billed 27 units of Community Access (H2021) on 1/3/2012. Documentation received accounted for 23 units<br><br>• The Agency billed 27 units of Community Access (H2021) on 1/4/2012. Documentation received accounted for 23 units<br><br>• The Agency billed 27 units of Community Access (H2021) on 1/5/2012. Documentation received accounted for 23 units<br><br>• The Agency billed 27 units of Community Access (H2021) on 1/10/2012. Documentation received accounted for 23 units<br><br>• The Agency billed 27 units of Community Access (H2021) on 1/19/2012. Documentation received accounted for 3 units | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>_____________________________________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| recoupment.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 5 XI. COMMUNITY ACCESS SERVICES REQUIREMENTS**<br>**G. Reimbursement**<br>(1) Billable Unit**:** A billable unit is defined as one-quarter hour of service.<br><br>(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:<br><br>(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;<br>(b) Time that is non face-to-face involves outreach and identification and training of community connections and natural supports; and<br>(c) Non face-to-face hours do not exceed 10% of the monthly billable hours.<br><br>(3) Non-Billable Activities**:** Activities that the service Provider Agency may need to conduct, but which are not separately billable activities, may include:<br>(a) Time and expense for training service personnel;<br>(b) Supervision of agency staff;<br>(c) Service documentation and billing activities; or<br>(d) Time the individual spends in segregated facility-based settings activities. | | | |

| Tag # 5I44 Adult Habilitation Reimbursement | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**<br>**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.<br>**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:<br>(1) Date, start and end time of each service encounter or other billable service interval;<br>(2) A description of what occurred during the encounter or service interval; and<br>(3) The signature or authenticated name of staff providing the service.<br><br>**MAD-MR: 03-59 Eff 1/1/2004**<br>**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**<br>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 | Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 5 of 17 individuals.<br><br>Individual #2<br>January 2012<br>• The Agency billed 19 units of Adult Habilitation (T2021, U2) from on 1/12/2012. Documentation did not contain the required elements on 1/12/2012. Documentation received accounted for 17 units.<br><br>Individual #13<br>February 2012<br>• The Agency billed 23 units of Adult Habilitation (T2021, U2) on 2/15/2012. Documentation received accounted for 21 units.<br><br>Individual #15<br>February 2012<br>• The Agency billed 24 units of Adult Habilitation (T2021, U4) on 2/8/2012. Documentation received accounted for 18 units.<br><br>• The Agency billed 24 units of Adult Habilitation (T2021, U1 & U4) on 2/28/2012. Documentation received accounted for 18 units.<br><br>Individual #17<br>December 2011<br>• The Agency billed 24 units of Adult Habilitation (T2021, U3) on 12/28/2011. Documentation received accounted for 16 units. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>____________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| recoupment.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 5 XVI. REIMBURSEMENT**<br>**A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care.<br><br>**B. Billable Activities**<br>(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.<br><br>(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours | • The Agency billed 24 units of Adult Habilitation (T2021, U3) on 12/29/2011. Documentation received accounted for 15 units.<br><br>February 2012<br>• The Agency billed 24 units of Adult Habilitation (T2021, U3) on 2/14/2012. Documentation received accounted for 15 units.<br><br>Individual #20<br>January 2012<br>• The Agency billed 24 units of Adult Habilitation (T2021, U2) from on 1/3/2012. Documentation received accounted for 22 units.<br><br>February 2012<br>• The Agency billed 24 units of Adult Habilitation (T2021, U2) from on 2/20/2012. Documentation received accounted for 22 units.<br><br>• The Agency billed 24 units of Adult Habilitation (T2021, U2) from on 2/21/2012. Documentation received accounted for 22 units.<br><br>• The Agency billed 24 units of Adult Habilitation (T2021, U2) from on 2/22/2012. Documentation received accounted for 22 units.<br><br>• The Agency billed 24 units of Adult Habilitation (T2021, U2) from on 2/23/2012. Documentation received accounted for 22 units. | | |

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| | • The Agency billed 24 units of Adult Habilitation (T2021, U2) from on 2/24/2012. Documentation received accounted for 22 units. | | |

| Tag # 6L26 Supported Living Reimbursement | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**<br>**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.<br>**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:<br>(1) Date, start and end time of each service encounter or other billable service interval;<br>(2) A description of what occurred during the encounter or service interval; and<br>(3) The signature or authenticated name of staff providing the service.<br><br>**MAD-MR: 03-59 Eff 1/1/2004**<br>**8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:**<br>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 | Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 2 of 16 individuals.<br><br>Individual #1<br>February 2012<br>• The Agency billed 1 units of Supported Living (T2033) on 2/26/2012. Documentation did not contain the required elements on 2/26/2012. Documentation received accounted for 0 units. One or more of the following elements was not met:<br>➢ No documentation found.<br><br>Individual #4<br>February 2012<br>• The Agency billed 1 unit of Supported Living (T2033) on 2/1/2012. Documentation did not contain the required elements on 2/1/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/2/2012. Documentation did not contain the required elements on 2/2/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/3/2012. Documentation did not contain the required elements on 2/3/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/4/2012. Documentation did not contain the required elements on 2/4/2012. | **Provider:**<br>State your Plan of Correction for the findings in this Tag *above* this line.<br>______________________<br>Enter your Quality Assurance/Quality Improvement processes *below* the line. | |

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| recoupment.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES**<br>A. **Reimbursement** for Supported Living Services<br>(1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year.<br>(2) **Billable Activities**<br>(a) Direct care provided to an individual in the residence any portion of the day.<br>(b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community.<br>(c) Any activities in which direct support staff provides in accordance with the Scope of Services.<br>(3) Non-Billable Activities<br>(a) The Supported Living Services provider shall not bill DD Waiver for Room and Board.<br>(b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services.<br>(c) The provider shall not bill when an individual is hospitalized or in an institutional care setting. | One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/5/2012. Documentation did not contain the required elements on 2/5/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/6/2012. Documentation did not contain the required elements on 2/6/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/7/2012. Documentation did not contain the required elements on 2/7/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/8/2012. Documentation did not contain the required elements on 2/8/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/9/2012. Documentation did not contain the required elements on 2/9/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/10/2012. Documentation did not contain the required elements on 2/10/2012. One of the following elements was not met:<br>➢ No documentation found. | | |

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| | • The Agency billed 1 unit of Supported Living (T2033) on 2/11/2012. Documentation did not contain the required elements on 2/11/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/12/2012. Documentation did not contain the required elements on 2/12/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/13/2012. Documentation did not contain the required elements on 2/13/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/14/2012. Documentation did not contain the required elements on 2/14/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/15/2012. Documentation did not contain the required elements on 2/15/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/16/2012. Documentation did not contain the required elements on 2/16/2012. One of the following elements was not met: | | |

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| | ➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/17/2012. Documentation did not contain the required elements on 2/17/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/18/2012. Documentation did not contain the required elements on 2/18/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/19/2012. Documentation did not contain the required elements on 2/19/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/20/2012. Documentation did not contain the required elements on 2/20/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/21/2012. Documentation did not contain the required elements on 2/21/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/22/2012. Documentation did not contain the required elements on | | |

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| | 2/22/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/23/2012. Documentation did not contain the required elements on 2/23/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/24/2012. Documentation did not contain the required elements on 2/24/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/25/2012. Documentation did not contain the required elements on 2/25/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/26/2012. Documentation did not contain the required elements on 2/26/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/27/2012. Documentation did not contain the required elements on 2/27/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living | | |

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| | (T2033) on 2/28/2012. Documentation did not contain the required elements on 2/28/2012. One of the following elements was not met:<br>➢ No documentation found.<br><br>• The Agency billed 1 unit of Supported Living (T2033) on 2/29/2012. Documentation did not contain the required elements on 2/29/2012. One of the following elements was not met:<br>➢ No documentation found. | | |

SUSANA MARTINEZ, GOVERNOR

BRAD McGRATH, INTERIM SECRETARY

Date: November 26, 2012

To: Pam Lillibridge, Chief Executive Officer
Provider: Tresco, Inc.
Address: 1800 Copper Loop
State/Zip: Las Cruces, New Mexico 88004

E-mail Address: PLillibridge@trescomail.org

Region: Southwest
Survey Date: March 26 - 29, 2012
Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: Community Living Supports (Supported Living & Independent Living) & Community Inclusion Supports (Adult Habilitation, Community Access & Supported Employment)
Survey Type: Routine

Dear Ms. Lillibridge;

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

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

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

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

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

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

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

Q.13.02.DDW.D1135.3.001.RTN.07.331