Dear Ms. Lillibridge:

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the Routine Survey on March 26 - 29, 2012, as well as your Plan of Correction regarding the IRC actions related to Individual Funds. The Division of Health Improvement, Quality Management Bureau has determined your agency is in:

**Compliance with Conditions of Participation**

However; due to the new/repeat deficiencies, your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator at 505-699-9356, if you have questions about the survey or the report.

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

Valerie V. Valdez, M.S.
Valerie V. Valdez, M.S.
Team Lead/Healthcare Program Manager
Division of Health Improvement
Quality Management Bureau
Survey Process Employed:

Entrance Conference Date: January 7, 2013

Present:

**Tresco, Inc.**
Pam Lillibridge, Chief Executive Officer
Maureen Gant, Program Support Manager

**DOH/DHI/QMB**
Valerie V. Valdez, MS, Team Lead/Healthcare Program Manager
Mari Chavez, BSW, Healthcare Surveyor
Cynthia Nielsen, RN, Healthcare Surveyor
Corrina Strain, RN, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor
Dan Maxwell, MS, DHI Deputy Division Director
Gayle Nash, RN, MPH, DOH Chief Nursing Officer

Exit Conference Date: January 9, 2013

Present:

**Tresco, Inc.**
Pam Lillibridge, Chief Executive Officer
Nicole Johnson, Quality Enhancement Manager
Maureen Gant, Program Support Manager
Virginia Valenzuela, Data Specialist/Documentation Coordinator

**DOH/DHI/QMB**
Valerie V. Valdez, MS, Team Lead/Healthcare Program Manager
Mari Chavez, BSW, Healthcare Surveyor
Cynthia Nielsen, RN, Healthcare Surveyor
Corrina Strain, RN, Healthcare Surveyor
Deb Russell, BS, Healthcare Surveyor
Dan Maxwell, MS, DHI Deputy Division Director

**DDSD - SW Regional Office**
Scott Doan, Regional Director

Total Homes Visited
Number: 12

- Supported Homes Visited
Number: 12

Administrative Locations Visited
Number: 1

Total Sample Size
Number: 20

- Jackson Class Members 9
- Non-Jackson Class Members 11
- Supported Living 13
- Independent Living 5
- Adult Habilitation 15
- Community Access 2
- Supported Employment 13

Note: 4 additional Individuals from the routine survey who receive services from Tresco Socorro were not seen during the verification survey.

Persons Served Records Reviewed
Number: 20
Direct Support Personnel Interviewed Number: 39
Direct Support Personnel Records Reviewed Number: 204
Service Coordinator Records Reviewed Number: 7

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  
DOH - Internal Review Committee
Attachment B

Department of Health, Division of Health Improvement
QMB Determination of Compliance Process

The Division of Health Improvement, Quality Management Bureau (QMB) surveys compliance of the Developmental Disabilities Waiver (DDW) standards and state and federal regulations. QMB has grouped the CMS assurances into five Service Domains: Level of Care; Plan of Care; Qualified Providers; Health, Welfare and Safety; and Administrative Oversight (note that Administrative Oversight listed in this document is not the same as the CMS assurance of Administrative Authority. Used in this context it is related to the agency’s operational policies and procedures, Quality Management system and Medicaid billing and reimbursement processes.)

The QMB Determination of Compliance process is based on the provider’s compliance or non-compliance with standards and regulations identified in the QMB Report of Findings. All deficiencies (non-compliance with standards and regulations) are identified and cited as either a Standard level deficiency or a Condition of Participation level deficiency in the QMB Reports of Findings. All deficiencies require corrective action when non-compliance is identified.

Within the QMB Service Domains there are fundamental regulations, standards, or policies with which a provider must be in essential compliance in order to ensure the health and welfare of individuals served known as Conditions of Participation (CoPs).

The Determination of Compliance for each service type is based on a provider’s compliance with CoPs in three (3) Service Domains.

Case Management Services:
- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:
- Qualified Provider
- Plan of Care
- Health, Welfare & Safety

Conditions of Participation (CoPs)

A CoP is an identified fundamental regulation, standard, or policy with which a provider must be in compliance in order to ensure the health and welfare of individuals served. CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances. A provider must be in compliance with CoPs to participate as a waiver provider.

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP. (See the next section for a list of CoPs.) The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team’s analysis establishes that there is an identified potential for significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.
The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

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

**Service Domain: Level of Care**

Condition of Participation:

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

**Service Domain: Plan of Care**

Condition of Participation:

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

Condition of Participation:

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

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

**Service Domain: Qualified Providers**

Condition of Participation:

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

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

**Service Domain: Plan of Care**

Condition of Participation:

5. **ISP Implementation**: Services provided shall be consistent with the components of the ISP and implemented to achieve desired outcomes.

**Service Domain: Health, Welfare & Safety**

Condition of Participation:

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

Condition of Participation:

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

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

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

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

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

Providers receiving a repeat determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.
Guidelines for the Provider
Informal Reconsideration of Finding (IRF) Process

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be 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: Verification Survey  
Routine Survey: March 26 - 29, 2012  
Verification Survey: January 7 – 9, 2013

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies Routine Survey March 26 – 29, 2012</th>
<th>New and Repeat Deficiencies Verification Survey January 7 – 9, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Service Plans: ISP Implementation</strong></td>
<td>Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Tag # 1A08 Agency Case File</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
</tr>
</tbody>
</table>
| Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 24 individuals. | New/Repeat Finding:  
Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 2 of 20 individuals. | |
| Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:  
- **Current Emergency & Personal Identification Information**  
  - Did not contain Health Plan Information (#21)  
- ISP Signature Page (#5 & 13)  
- Documentation of Guardianship/Power of Attorney (#1)  
- Dental Exam  
  - Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of current exam was found | Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:  
- Speech Therapy Plan (#19)  
- Vision Exam  
  - 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.  
- Pap Smear Exam  
  - Individual #7 - As indicated by collateral documentation reviewed, a Pap Smear referral was made during the annual exam on 8/16/2012. No evidence of exam found. |

Survey Report #: Q.13.3.DDW.D1135.3.001.VER.01.023
(1) Emergency contact information, including the individual’s address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician’s name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;
(2) The individual’s complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);
(3) Progress notes and other service delivery documentation;
(4) Crisis Prevention/Intervention Plans, if there are any for the individual;
(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;
(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and
(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.
(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:
   (a) Complete file for the past 12 months;
   (b) ISP and quarterly reports from the current and prior ISP year;
   (c) Intake information from original admission to services; and
   (d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

- **Vision Exam**
  - 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.

- **Cholesterol & Blood Glucose**
  - Individual #10 - As indicated by collateral documentation reviewed, lab work was ordered on 10/29/11. No evidence of lab results was found.

- **Colonoscopy**
  - Individual #7 - As indicated by collateral documentation reviewed, a Colonoscopy referral was made during the annual exam on 8/16/2012. No evidence of exam found.
**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

**B. Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
**Tag # 6L14  Residential Case File**

**Standard Level Deficiency**

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.

The following was not found, incomplete and/or not current:

- **Current Emergency & Personal Identification Information**
  - Did not contain name and phone numbers of relatives, or guardian or conservator Information (#2)
  - Did not contain Individual’s Current Address (#3, 12 & 23)
  - Did not contain Individual’s Phone Number Information (#3)
  - Did not contain Individual’s Health Plan Information (#24)

- **Positive Behavioral Plan (#17, 18 & 24)**
- **Positive Behavioral Crisis Plan (#3, 14, 17, 18, 23 & 24)**
- **Speech Therapy Plan (#1 & 24)**
- **Occupational Therapy Plan (#1, 17 & 24)**
- **Special Health Care Needs**
  - CARMP (#3)
  - Meal Time Plan (#15)
  - Comprehensive Aspiration Risk Management Plan (#14, 16 & 23)

**New/Repeat Finding:**

Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 5 of 13 Individuals receiving Supported Living Services.

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

- **Annual ISP (#23)**
- **Individual Specific Training Section of ISP (#23)**
- **Positive Behavioral Crisis Plan (#18)**
- **Speech Therapy Plan (#15)**
- **Physical Therapy Plan (#23)**

**Special Health Care Needs**

- Aspiration (#3 & 14)
- Weight/Body Mass Index (#3 &18)

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

**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**

**A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual’s home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual’s home, the complete and current confidential case file for each individual shall be maintained at the agency’s administrative site. Each file shall include the following:

1. Complete and current ISP and all supplemental plans specific to the individual;
2. Complete and current Health Assessment Tool;
3. Current emergency contact information, which includes the individual’s address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician’s name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;
4. Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
5. Data collected to document ISP Action Plan implementation
6. Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
(7) Physician’s or qualified health care providers written orders;
(8) Progress notes documenting implementation of a physician’s or qualified health care provider’s order(s);
(9) Medication Administration Record (MAR) for the past three (3) months which includes:
   (a) The name of the individual;
   (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;
   (c) Diagnosis for which the medication is prescribed;
   (d) Dosage, frequency and method/route of delivery;
   (e) Times and dates of delivery;
   (f) Initials of person administering or assisting with medication; and
   (g) An explanation of any medication irregularity, allergic reaction or adverse effect.
(h) For PRN medication an explanation for the use of the PRN must include:
   (i) Observable signs/symptoms or circumstances in which the medication is to be used, and
   (ii) Documentation of the effectiveness/result of the PRN delivered.
(i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual’s home and an updated copy must be placed in the agency file on a weekly basis.
(10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and
(11) Medical History to include: demographic data, current and past medical diagnoses including the

<table>
<thead>
<tr>
<th>Crisis Plan/Medical Emergency Response Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>◦ Constipation (#3)</td>
</tr>
<tr>
<td>◦ Oral Care (#3)</td>
</tr>
<tr>
<td>◦ Seizures (#1)</td>
</tr>
<tr>
<td>◦ Skin Integrity (#18)</td>
</tr>
<tr>
<td>◦ Allergies (#5)</td>
</tr>
<tr>
<td>◦ Weight/Body Mass Index (#2)</td>
</tr>
<tr>
<td>◦ Falls (#16, 17 &amp; 18)</td>
</tr>
<tr>
<td>◦ Gastrointestinal (#16)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Progress Notes/Daily Contacts Logs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>◦ Individual #1 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #2 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #3 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #5 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #12 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #13 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #14 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #15 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #16 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #17 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #18 - None found for 3/1 – 24, 2012.</td>
</tr>
<tr>
<td>◦ Individual #23 - None found for 3/1 – 24, 2012.</td>
</tr>
</tbody>
</table>
cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.
Standard of Care

**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.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Direct Support Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A20</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 8 of 189 Direct Support Personnel.</td>
<td>New/Repeat Finding: Based on review of training records, Direct Support Personnel training records showed no evidence of the following required DOH/DDSD trainings and certification being completed for 1 of 204 Direct Support Personnel.</td>
</tr>
<tr>
<td></td>
<td><strong>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:</strong> The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>C. Orientation and Training Requirements:</strong> Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td>• Person-Centered Planning (1-Day) (DSP #106)</td>
<td>• Person-Centered Planning (1-Day) (DSP #268)</td>
</tr>
<tr>
<td></td>
<td>(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</td>
<td>• First Aid (DSP #234)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) Individual-specific training for each individual under his or her direct care, as described in the individual service plan, prior to working alone with the individual.</td>
<td>• CPR (DSP #76, 201 &amp; 234)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assisting With Medication Delivery (DSP #71, 123, 145 &amp; 185)</td>
<td></td>
</tr>
</tbody>
</table>
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 -  
II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.
E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.
F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.
G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques.
H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.
I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone...
<table>
<thead>
<tr>
<th>Tag # 1A22 Agency Personnel Competency</th>
<th>Condition of Participation Level Deficiency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td>New/Repeat Finding:</td>
</tr>
<tr>
<td>CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL: The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.</td>
<td>Based on interview, the Agency failed to ensure that training competencies were met for 13 of 42 Direct Support Personnel.</td>
<td>Based on interview, the Agency failed to ensure training competencies were met for 1 of 39 Direct Support Personnel.</td>
</tr>
<tr>
<td>F. Qualifications for Direct Service Personnel: The following employment qualifications and competency requirements are applicable to all Direct Service Personnel employed by a Provider Agency: (1) Direct service personnel shall be eighteen (18) years or older. Exception: Adult Habilitation can employ direct care personnel under the age of eighteen 18 years, but the employee shall work directly under a supervisor, who is physically present at all times; (2) Direct service personnel shall have the ability to read and carry out the requirements in an ISP; (3) Direct service personnel shall be available to communicate in the language that is functionally required by the individual or in the use of any specific augmentative communication system utilized by the individual; (4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators,</td>
<td>When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:</td>
<td>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td>• 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)</td>
<td>• 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)</td>
</tr>
<tr>
<td></td>
<td>• DSP #186 stated, “No, not a crisis plan.” According to the Individual Specific Training Section of the ISP, the individual requires Positive Behavioral Crisis Plan. (Individual #14)</td>
<td>• DSP #186 stated, “No, not a crisis plan.” According to the Individual Specific Training Section of the ISP, the individual requires Positive Behavioral Crisis Plan. (Individual #14)</td>
</tr>
</tbody>
</table>
Serving Individuals with Developmental Disabilities; and

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

(6) Report required personnel training status to the DDSD Statewide Training Database as specified in DDSD policies as related to training requirements as follows:

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

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

A. Individuals shall receive services from competent and qualified staff.

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)

When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:

- 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)

- 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)

- DSP #66 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for seizures. (Individual #8)

- DSP #74 stated, “No.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for weight/BMI. (Individual #10)

- DSP #90 stated, “Just for picking at her skin.” As indicated by the Agency file, the Individual requires Health Care Plans for weight/BMI, oral care, aspiration & constipation. (Individual #3)

- DSP #95 stated, “Probably Autism and Hypothyroidism.” According to the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for oral care.
care & constipation. (Individual #5)

- 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)

- 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)

- 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)

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

- DSP #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)

- DSP #66 stated, “No, her mom took care of all that.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for falls. (Individual #7)

- 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)

- 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)

- 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)

- 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)

- 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)

When DSP were asked if the Individual had a Seizure Disorder, the following was reported:

- DSP #66 stated, “No, I wasn’t aware till I read 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)

When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was
reported:

- DSP #132 stated, “No, he doesn’t.” Per Therap the individual has an allergy to Cefotan. (Individual #2)

- DSP #234 stated, “No.” Per Therap the individual has an allergy to Lindane, Boniva and silk tape. (Individual #12)

When DSP were asked to describe what medications are prescribed for the individual, the following was reported:

- 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)
Standard of Care

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

<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies Routine Survey March 26 – 29, 2012</th>
<th>New and Repeat Deficiencies Verification Survey January 7 – 9, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHAPTER 1 PROVIDER AGENCY ENROLLMENT PROCESS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I. Continuous Quality Management System:</strong> Prior to approval or renewal of a DD Waiver Provider Agreement, the Provider Agency is required to submit in writing the current Continuous Quality Improvement Plan to the DOH for approval. In addition, on an annual basis DD Waiver Provider Agencies shall develop or update and implement the Continuous Quality Improvement Plan. The CQI Plan shall be used to 1) discover strengths and challenges of the provider agency, as well as strengths, and barriers individuals experience in receiving the quality, quantity, and meaningfulness of services that he or she desires; 2) build on strengths and remediate individual and provider level issues to improve the provider’s service provision over time. At a minimum the CQI Plan shall address how the agency will collect, analyze, act on data and evaluate results related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Individual access to needed services and supports;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Effectiveness and timeliness of implementation of Individualized Service Plans;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Trends in achievement of individual outcomes in the Individual Service Plans;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Trends in medication and medical incidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on record review, the Agency failed to implement their Continuous Quality Management System as required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In addition, review of collateral documentation indicated the agency has failed to address and/or implement improvement actions as they relate to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trends in medication and medical incidents leading to adverse health events;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New/Repeat Finding:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on record review and interview, the Agency has not fully implemented the Continuous Quality Management System as required by standard.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Review of the findings identified during the routine on-site survey (March 26 – 29, 2012) and as reflected in this report of findings, the Agency continues to have deficiencies noted. Interviews with staff, #236 &amp; 290 indicate plans and processes are in place and being worked on; yet at the time of the verification survey full implementation results have not achieved desired outcomes, as the system has not been in place a sufficient amount of time.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
leading to adverse health events;
(5) Trends in the adequacy of planning and coordination of healthcare supports at both supervisory and direct support levels;
(6) Quality and completeness documentation; and
(7) Trends in individual and guardian satisfaction.

7.1.13.9 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY BASED SERVICE PROVIDERS:
E. Quality Improvement System for Community Based Service Providers: The community based service provider shall establish and implement a quality improvement system for reviewing alleged complaints and incidents. The incident management system shall include written documentation of corrective actions taken. The community based service provider shall maintain documented evidence that all alleged violations are thoroughly investigated, and shall take all reasonable steps to prevent further incidents. The community based service provider shall provide the following internal monitoring and facilitating quality improvement system:
   (1) community based service providers funded through the long-term services division to provide waiver services shall have current incident management policy and procedures in place, which comply with the department's current requirements;
   (2) community based service providers providing developmental disabilities services must have a designated incident management coordinator in place;
   (4) community based service providers providing developmental disabilities services must have an incident management committee to address internal and external incident reports for the purpose of looking at internal root causes and to take action on identified trends or issues.
### Tag # 1A09  Medication Delivery (MAR) - Routine Medication

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

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

#### E. Medication Delivery:
Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

- 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;
- Prescribed dosage, frequency and method/route of administration, times and dates of administration;
- Initials of the individual administering or assisting with the medication;
- Explanation of any medication irregularity;
- Medication Administration Records (MAR) were reviewed for the months of January, February & March of 2012.
- Based on record review, 6 of 24 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:

<table>
<thead>
<tr>
<th>Individual #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2012</td>
</tr>
<tr>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
</tr>
<tr>
<td>- Citrucel (1 time daily)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2012</td>
</tr>
<tr>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
</tr>
<tr>
<td>- Citrucel (1 time daily)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #9</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2012</td>
</tr>
<tr>
<td>Agency’s “MAR Comment Sheet (Form No: PS809)” did not contain the Name of the Individual.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #12</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2012</td>
</tr>
<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td>- Peridex (2 times daily) – Blank 12/15, 16, 22, 23, 29, 30 &amp; 31 (8 AM) &amp; 12/16, 23, 29, 30 &amp; 31 (8PM).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #16</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2012</td>
</tr>
<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td>- Oyster Shell 500 (2 times daily) – Blank 1/6 (8 AM)</td>
</tr>
</tbody>
</table>

#### New/Repeat Finding:
Medication Administration Records (MAR) were reviewed for the months of December 2012 & January 2013.

<table>
<thead>
<tr>
<th>Individual #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2013</td>
</tr>
<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td>- Oyster Shell 500 (2 times daily) – Blank 1/6 (8 AM)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #9</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2012</td>
</tr>
<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td>- Oyster Shell 500 (2 times daily) – Blank 1/6 (8 AM)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #12</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2012</td>
</tr>
<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td>- Peridex (2 times daily) – Blank 12/15, 16, 22, 23, 29, 30 &amp; 31 (8 AM) &amp; 12/16, 23, 29, 30 &amp; 31 (8PM).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual #16</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2012</td>
</tr>
<tr>
<td>Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:</td>
</tr>
<tr>
<td>- Oyster Shell 500 (2 times daily) – Blank 1/6 (8 AM)</td>
</tr>
</tbody>
</table>
(e) Documentation of any allergic reaction or adverse medication effect; and

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;

(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

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

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;
   (ii) Date given;
   (iii) Drug product name;
   (iv) Dosage and form;
   (v) Strength of drug;
   (vi) Route of administration;
   (vii) How often medication is to be taken;

March 2012
- 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.

Individual #12
March 2012
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:
- 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)
- 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)

Individual #20
February 2012
Medication Administration Records did not contain the route of administration for the following medications:
- Apri Birth Control (1 time daily)
- Ciclopirox Cream 6.6 ml (1 time daily)
- Desitin Cream (apply after bath)
- Hydrocortisone 28.4 gm (1 time daily)
- Hydroxyzine 100 mg (1 time daily)
- Levothyroxine 50mcg (1 time daily)
- Loratadine 10mg (1 time daily)
- Paxil 20 mg (1 time daily) – Blank 12/17 (8 AM)
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual
D. Administration of Drugs
Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:
- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

- Magnesium Oxide (2 times daily)
- Multivitamin 1000mg (1 time daily)
- Nystantin (apply after bath)
- Celexa 40mg (1 time daily)
- Clomipramine 75mg (1 time daily)
- Cogentin 1mg (time daily)
- Haloperidol .5mg (2 times daily)
- Pilosec 20mg (1 time daily)
- Probiotic Lactobacillus (2 times daily)

Individual #22
January 2012
Medication Administration Records did not contain the route of administration for the following medications:
- Allegra 60mg (2 times daily)
- Fosamax 70mg (1 time daily)
- Gemfibrozil 600mg (2 times daily)
- Hydroxyzine 25mg (3 times daily)
- Levothyroxine 100mcg (1 time daily)
- Lotrisone Cream 1%/0.05% (2 times daily)
- Metformin 500mg (2 times daily)
- Ultram 50mg (3 times daily)
- Vitamin D 400 unit (1 time daily)
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin B12 1000mcg</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Trazadone 200mg</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Zoloft 200mg</td>
<td>1 time daily</td>
</tr>
</tbody>
</table>

February 2012
Medication Administration Records did not contain the route of administration for the following medications:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegra 60mg</td>
<td>2 times daily</td>
</tr>
<tr>
<td>Fosamax 70mg</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Gemfibrozil 600 mg</td>
<td>2 times daily</td>
</tr>
<tr>
<td>Hydroxyzine 25mg</td>
<td>3 times daily</td>
</tr>
<tr>
<td>Levothyroxine 100mcg</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Metformin 500mg</td>
<td>2 times daily</td>
</tr>
<tr>
<td>Ultram 50mg</td>
<td>3 times daily</td>
</tr>
<tr>
<td>Vitamin D 400 unit</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Vitamin B12 1000mcg</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Trazadone 200mg</td>
<td>1 time daily</td>
</tr>
<tr>
<td>Zoloft 200mg</td>
<td>1 time daily</td>
</tr>
</tbody>
</table>

Individual #23
January 2012
Medication Administration Records did not contain the strength of the medication which is to be given:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilantin</td>
<td>2 times daily</td>
</tr>
</tbody>
</table>
• Metoclopramide (3 times daily)

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:
• Dilantin (2 times daily)
<table>
<thead>
<tr>
<th>Tag # 1A09.1 Medication Delivery - PRN Medication</th>
<th>Standard Level Deficiency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
</table>

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

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

**E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations.

(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:

(a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;
(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;

<table>
<thead>
<tr>
<th>Individual #1</th>
<th>February 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</td>
<td></td>
</tr>
<tr>
<td>• Triazolam .25 mg (PRN)</td>
<td></td>
</tr>
</tbody>
</table>

**No Effectiveness was noted on the Medication Administration Record for the following PRN medication:**

<table>
<thead>
<tr>
<th>Individual #6</th>
<th>January 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
<td></td>
</tr>
<tr>
<td>• Metamucil (PRN)</td>
<td></td>
</tr>
</tbody>
</table>

**No Effectiveness was noted on the Medication Administration Record for the following PRN medication:**

<table>
<thead>
<tr>
<th>Individual #12</th>
<th>March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Administration Records did not contain the exact amount to be used in a 24 hour period:</td>
<td></td>
</tr>
<tr>
<td>• Robaxin 500 mg (PRN)</td>
<td></td>
</tr>
</tbody>
</table>

**New/Repeat Finding:**

Medication Administration Records (MAR) were reviewed for the months of December 2012 & January 2013.

Based on record review, 1 of 20 individuals had PRN Medication Administration Records, which contained missing elements as required by standard:

- **Individual #9 December 2012**
  - “Med Comments Sheet/PRN Meds Taken” page of Medication Administration Records indicated the following medication was given on 12/4 & 11 (given 1 time). The following medications were not documented on the Medication Administration Records:
    - Robaxin 500 mg (PRN)
  - “Med Comments Sheet/PRN Meds Taken” page of Medication Administration Records contain the following medications as being given on 12/4 & 11 (given 1 time). No Physician’s Orders were found for the following medications:
    - Robaxin 500 mg (PRN)
  - Agency’s “MAR Comment Sheet/PRN Meds Taken (Form No: PS809)” did not contain the Name of the Individual.

Medication Administration Records did not contain the exact amount to be used in a 24 hour period:

- Robaxin 500 mg (PRN)
(e) Documentation of any allergic reaction or adverse medication effect; and

(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;

(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;

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

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include:
   (i) Name of resident;
   (ii) Date given;
   (iii) Drug product name;
   (iv) Dosage and form;
   (v) Strength of drug;

   Medication:  
   • Ativan 2 mg – PRN – 3/14 & 16 (given 1 time) & 3/15 (given 2 times)

   Medication Administration Record document did not contain staff’s initial, used to document administered or assisted delivery of each dose for the following medications:
   • Ativan 2 mg – PRN – 3/15/2012 (10AM)

   Individual #23  
   January 2012

   Medication Administration Records did not contain the route of administration for the following medications:
   • Acetometephin 500mg (PRN)

   February 2012

   Medication Administration Records did not contain the route of administration for the following medications:
   • Acetometephin 500mg (PRN)

   Medication Administration Records did not contain the route of administration for the following medications:
   • Robaxin 500 mg (PRN)

   Medication Administration Records did not contain the route of administration for the following medications:
   • Robaxin 500 mg (PRN)

   Medication Administration Record did not contain the form (i.e. liquid, tablet, capsule, etc.) of medication to be taken for the following:

   • Robaxin 500 mg (PRN)
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual

D. Administration of Drugs

Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications.

Document the practitioner’s order authorizing the self-administration of medications.

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:
- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Department of Health

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

F. PRN Medication

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

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

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

Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title: Medication Assessment and Delivery Procedure
Eff Date: November 1, 2006

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

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

4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).
### Tag # 1A15.2 & 5I09 - Healthcare Documentation

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

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

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

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

(b) The provider agency must arrange for their nurse to complete the Health Assessment Tool (HAT) and the Medication Administration Assessment Tool (MAAT) on at least an annual basis for each individual receiving community living, community inclusion or private duty nursing services, unless the provider agency arranges for the individual’s Primary Care Practitioner (PCP) to voluntarily complete these assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have

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<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 2 of 20 individuals.</td>
</tr>
</tbody>
</table>

**The following were not found, incomplete and/or not current:**

- **Comprehensive Aspiration Risk Management Plan** (#14)
- **Special Healthcare Needs:**
  - **Nutritional Plan**
    - Individual #20 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - Individual #20 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.
  - **Constipation**
    - Individual #9 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
  - **Weight/Body Mass Index**
    - Individual #20 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
  - **Falls**
  - **Crisis Plans/Medical Emergency Response Plans**
    - **Allergies**
      - Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

**New/Repeat Finding:**

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

- **Electronic Comprehensive Health Assessment Tool (eChat) (#18)**
- **Special Health Care Needs:**
  - **Nutritional Plan**
    - Individual #19 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request.

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

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

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

(2) Health related plans

- Individual #7 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional.
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan.
(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee.
(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):
   (a) Each healthcare plan must include a statement of the person’s healthcare needs and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.
   (b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the
goal.
(c) Approaches described in the plan shall be individualized to reflect the individual’s unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.
(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.
(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.
(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a hospitalization.
(g) All crisis prevention and intervention plans and healthcare plans shall include the individual’s name and date on each page and shall be signed by the author.
(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

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


CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS

B. IDT Coordination

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

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

Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010

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

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
**Tag # 1A33 Board of Pharmacy - Med Storage**

<table>
<thead>
<tr>
<th>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual</th>
<th>Standard Level Deficiency</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Medication Storage:</strong></td>
<td>Based on record review and observation, the Agency failed to ensure proper storage of medication for 1 of 24 individuals. Observation included: Individual #12  • Betadine 7.5% lotion was not kept separate from medications to be administered orally.</td>
<td>New/Repeat Finding: Based on observation, the Agency failed to ensure proper storage of medication for 1 of 20 individuals. Observation included: Individual #23  • Calcitonin Nasal Spray was not in a locked container as required by regulation. Medication was stored in a box in the refrigerator which was not locked.</td>
</tr>
<tr>
<td>b. time administered</td>
<td></td>
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<td>----------------------</td>
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<td></td>
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<tr>
<td>c. name of patient</td>
<td></td>
<td></td>
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<tr>
<td>d. dose</td>
<td></td>
<td></td>
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<tr>
<td>e. practitioner’s name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. signature of person administering or assisting with the administration the dose</td>
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<td></td>
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<tr>
<td>g. balance of controlled substance remaining.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 6L13 Community Living Healthcare Reqts.</td>
<td>Standard Level Deficiency</td>
<td>Standard Level Deficiency</td>
</tr>
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<td>---------------------------------------------</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>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.</td>
<td>New/Repeat Finding: 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 18 individuals receiving Community Living Services.</td>
</tr>
</tbody>
</table>
| CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING G. Health Care Requirements for Community Living Services (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the individual’s health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first. | The following was not found, incomplete and/or not current:  
- **Dental Exam**  
  - 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.  
- **Vision Exam**  
  - Individual #8 - As indicated by the DDSD file matrix Vision Exams are to be conducted annually. No evidence of exam was found.  
- **Bone Density Exam**  
  - Individual #16 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.  
- **Auditory Exam**  
  - 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.  
- **Psychological Assessment**  
  - Individual #20 - As indicated by collateral documentation reviewed, exam was ordered at 7 weeks prior to the annual 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. | Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:  
- **Dental Exam**  
  - Individual #19 - As indicated by collateral documentation reviewed, exam was completed on 11/15/2011. Follow-up was to be completed in 1 year. No evidence of follow-up found.  
- **Bone Density Exam**  
  - Individual #1 - As indicated by collateral documentation reviewed, a Bone Density Exam was ordered by the Primary Care Physician on 1/26/2012. No evidence of exam was found.  
- **Pap Smear Exam**  
  - Individual #24 - As indicated by collateral documentation reviewed, a Pap Smear was to be completed on 4/10/2012. Doctor’s notes indicated individual “refused.” No evidence of exam was found nor evidence of actions taken by the IDT.  
  - Individual #18 - As indicated by collateral documentation reviewed, a referral for a Pap Smear was made during the Annual Physical on 12/30/2011. No evidence of exam was found nor evidence of actions taken by the IDT. |
| (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual’s HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following:  
(a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services. |  |  |
Community Inclusion Services and Private Duty Nursing Services.

b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse.

(c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.

(4) That an average of 3 hours of documented nutritional counseling is available annually, if recommended by the IDT.

(5) That the physical property and grounds are free of hazards to the individual’s health and safety.

(6) In addition, for each individual receiving Supported Living or Family Living Services, the provider shall verify and document the following:
   (a) The individual has a primary licensed physician;
   (b) The individual receives an annual physical examination and other examinations as specified by a licensed physician;
   (c) The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;
   (d) The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and
   (e) Agency activities that occur as follow-up to medical appointments (e.g. treatment, visits to specialists, changes in medication or daily routine).

NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible individual.

<table>
<thead>
<tr>
<th>Survey Report #: Q.13.3.DDW.D1135.3.001.VER.01.023</th>
</tr>
</thead>
</table>

### Pap Smear Exam
- 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.

### Mammogram Exam
- 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.

### Bone Density Exam
- 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.

### Blood Levels
- Individual #21 - As indicated by collateral documentation reviewed, lab work was ordered on 11/10/2011. No evidence of lab work found.

### Coloscopy
- Individual #18 - As indicated by collateral documentation reviewed, a referral for a Colonoscopy was made during the Annual Physical on 12/30/2011. No evidence of exam was found nor actions taken by the IDT.

### Endoscopy
- Individual #18 - As indicated by collateral documentation reviewed, a referral for an Endoscopy was made during the Annual Physical on 12/30/2011. No evidence of exam was found nor evidence of actions taken by the IDT.

### Auditory Exam
- Individual #8 - As indicated by collateral documentation reviewed, exam was to be scheduled. No evidence of exam found.

### Lab Work
- Individual #12 - As indicated by collateral documentation reviewed, lab work for Cortisol level was performed on 4/19/2012. No evidence of lab results was found.

### Mammogram Exam
- Individual #18 - As indicated by collateral documentation reviewed, a referral for a Mammogram was made during the Annual Physical on 12/30/2011. No evidence of exam was found nor actions taken by the IDT.

- Individual #19 - As indicated by collateral documentation reviewed, a referral for a Mammogram was made by the Physician Care Physician on 9/27/2012. No evidence of exam was found nor evidence of actions taken by the IDT.

### Colonoscopy
- Individual #18 - As indicated by collateral documentation reviewed, a referral for a Colonoscopy was made during the Annual Physical on 12/30/2011. No evidence of exam was found nor evidence of actions taken by the IDT.

- Individual #19 - As indicated by collateral documentation reviewed, a referral for a Colonoscopy was made by the Physician Care Physician on 9/27/2012. No evidence of exam was found nor evidence of actions taken by the IDT.

### Endoscopy
- Individual #18 - As indicated by collateral documentation reviewed, a referral for an Endoscopy was made during the Annual Physical on 12/30/2011. No evidence of exam was found nor evidence of actions taken by the IDT.

### Auditory Exam
- Individual #8 - As indicated by collateral documentation reviewed, exam was to be scheduled. No evidence of exam found.

### Lab Work
- Individual #12 - As indicated by collateral documentation reviewed, lab work for Cortisol level was performed on 4/19/2012. No evidence of lab results was found.
recipient who is currently receiving or who has received services in the past.

B. **Documentation of test results**: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.

- Individual #12 - As indicated by collateral documentation reviewed, lab work for Myosolin levels was performed on 11/26/2012. No evidence of lab results was found.

- **Abnormal Involuntary Movement Screening/Tardive Dyskinesia Screenings**
  - None found for Reglan (#23)
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies Routine Survey March 26 – 29, 2012</th>
<th>New and Repeat Deficiencies Verification Survey January 7 – 9, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Assurance – Service Plans: ISP Implementation</strong> – Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</td>
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<tr>
<td>Tag # 1A08.1 Agency Case File - Progress Notes</td>
<td>Standard Level Deficiency</td>
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<tr>
<td>Tag # 1A32 &amp; 6L14 ISP Implementation</td>
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<td>Tag # 5I22 SE Agency Case File</td>
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<tr>
<td>Tag # 6L17 Reporting Requirements (Community Living Quarterly Reports)</td>
<td>Standard Level Deficiency</td>
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</tr>
<tr>
<td><strong>CMS Assurance – Qualified Providers</strong> – 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.</td>
<td></td>
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<tr>
<td>Tag # 1A11.1 Transportation Training</td>
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<tr>
<td>Tag # 1A28.1 Incident Mgt. System - Personnel Training</td>
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<tr>
<td>Tag # 1A36 Service Coordination Requirements</td>
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<tr>
<td>Tag # 1A37 Individual Specific Training</td>
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<tr>
<td><strong>CMS Assurance – Health and Welfare</strong> – 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.</td>
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<td>Tag # 1A27 Incident Mgt Late &amp; Failure to Report</td>
<td>Standard Level Deficiency</td>
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<td>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</td>
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Survey Report #: Q.13.3.DDW.D1135.3.001.VER.01.023
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<th>Tag #</th>
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<tr>
<td>1A31</td>
<td>Client Rights/Human Rights</td>
<td>Standard Level Deficiency</td>
</tr>
<tr>
<td>6L25</td>
<td>Residential Health &amp; Safety (Supported Living &amp; Family Living)</td>
<td>Standard Level Deficiency</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Tag #</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
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<td>5I25</td>
<td>Supported Employment Reimbursement</td>
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<tr>
<td>5I36</td>
<td>Community Access Reimbursement</td>
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<tr>
<td>5I44</td>
<td>Adult Habilitation Reimbursement</td>
<td>Standard Level Deficiency</td>
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<tr>
<td>6L26</td>
<td>Supported Living Reimbursement</td>
<td>Standard Level Deficiency</td>
</tr>
</tbody>
</table>
Date: February 15, 2013

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
Routine Survey: March 26 - 29, 2012
Verification Survey: January 7 – 9, 2013
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: Verification

Dear Ms. Lillibridge;

Your request for a Reconsideration of Findings was received on February 8, 2013. Your request and the supporting evidence provided have been reviewed. Based on the review of applicable standards and regulations, review of the survey process and the evidence you provided, the following determinations have been made:

Regarding Tag # 1A2
Determination: The IRF committee is removing the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on the documentation supplied regarding the non-required Positive Behavior Crisis Plan, the findings for Individual #18 in regards to the PBCP will be removed.

Regarding Tag # 6L14
Determination: The IRF committee is modifying the original finding in the report of findings. You are required to complete the remainder of your Plan of Correction as previously indicated. Based on documentation supplied regarding the non-required Positive Behavior Crisis Plan, the findings for Individual #18 in regards to the PBCP will be removed. The remaining citations noted in tag 6L14 were not disputed.

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

Thank you.
Respectfully,

Scott Good
Deputy Bureau Chief/QMB
Informal Reconsideration of Finding Committee Chair
Date: August 30, 2013

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
Routine Survey: March 26 - 29, 2012
Verification Survey: January 7 – 9, 2013
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: Verification

Dear Ms. Lillibridge;

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete. However, your case with the Internal Review Committee will remain open.

Your agency is now determined to be in Compliance with all Conditions of Participation.

The IRC will continue to monitor implementation of your quality systems and use of your Agency’s Quality Improvement Plan.

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

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

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

Sincerely,

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

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