Dear Ms. Denson;

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

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

*Partial Compliance with Conditions of Participation*

This determination is based on non compliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.
Plan of Correction:
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency’s compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the receipt of this letter.

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

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

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

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

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

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

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

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

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

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

Sincerely,

Deb Russell, BS
Deb Russell, BS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Report #: Q.13.2.DDW.D1644.4.001.RTN.01.052
**Survey Process Employed:**

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<th>Entrance Conference Date:</th>
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<tr>
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<td></td>
</tr>
<tr>
<td><strong>Zia Therapy Center, Inc.</strong></td>
<td></td>
</tr>
<tr>
<td>Sherill Bodwell, Chief Operating Officer</td>
<td></td>
</tr>
<tr>
<td>Denise Kohls, Service Coordinator</td>
<td></td>
</tr>
<tr>
<td>Dolores Carrillo, Adult Services Assistant Manager</td>
<td></td>
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<tr>
<td><strong>DOH/DHI/QMB</strong></td>
<td></td>
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<tr>
<td>Deb Russell, BS, Team Lead/Healthcare Surveyor</td>
<td></td>
</tr>
<tr>
<td>Mari Chavez, BSW, Healthcare Surveyor</td>
<td></td>
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<tr>
<td>Amanda Castaneda, MPA, Healthcare Surveyor</td>
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<table>
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<tr>
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<tr>
<td><strong>Zia Therapy Center, Inc.</strong></td>
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<td>Peggy Denson, Chief Executive Officer</td>
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<td>Dolores Carrillo, Adult Services Assistant Manager</td>
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<td>Diana Landers, Billing Specialist</td>
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<td>Barbara House, Adult Services Manager</td>
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<tr>
<td>Sharon Gilsdorf, Chief Financial Officer</td>
<td></td>
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<td><strong>DOH/DHI/QMB</strong></td>
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<tr>
<td>Deb Russell, BS, Team Lead/Healthcare Surveyor</td>
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<td>Mari Chavez, BSW, Healthcare Surveyor</td>
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<tr>
<td>Amanda Castaneda, MPA, Healthcare Surveyor</td>
<td></td>
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<tr>
<td><strong>DDSD – Southwest Regional Office</strong></td>
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<tr>
<td>Scott Doan, Southwest Regional Manager via telephone</td>
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</table>

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<thead>
<tr>
<th>Administrative Locations Visited</th>
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<tbody>
<tr>
<td>Total Sample Size</td>
<td>Number: 10</td>
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<tr>
<td>0 - Jackson Class Members</td>
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</tr>
<tr>
<td>10 - Non-Jackson Class Members</td>
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</tr>
<tr>
<td>4 - Family Living</td>
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<td>10 - Adult Habilitation</td>
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<tr>
<td>4 - Community Access</td>
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<td>3 - Supported Employment</td>
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<table>
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<tbody>
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</tr>
<tr>
<td>Persons Served Records Reviewed</td>
<td>Number: 10</td>
</tr>
<tr>
<td>Persons Served Interviewed</td>
<td>Number: 5</td>
</tr>
<tr>
<td>Persons Served Observed</td>
<td>Number: 5 (2 Individuals chose not to participate in the survey interview as they were preparing to leave for another activity; 3 Individuals were not available during the on-site survey)</td>
</tr>
<tr>
<td>Direct Support Personnel Interviewed</td>
<td>Number: 6</td>
</tr>
</tbody>
</table>
Direct Support Personnel Records Reviewed  Number:  52
Service Coordinator Records Reviewed  Number:  6

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
  - Individual Service Plans
  - Progress on Identified Outcomes
  - Healthcare Plans
  - Medication Administration Records
  - Medical Emergency Response Plans
  - Therapy Evaluations and Plans
  - Healthcare Documentation Regarding Appointments and Required Follow-Up
  - Other Required Health Information
- Internal Incident Management Reports and System Process
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and Service Locations
- Quality Assurance / Improvement Plan

CC: Distribution List:
DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
DOH – Internal Review Committee
Attachment A

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

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

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

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

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

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

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

Instructions for Completing Agency POC:

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

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

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

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

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

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

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

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

6. QMB will notify you when your POC has been “approve” or “denied.”
   a. During this time, whether your POC is “approved,” or “denied,” you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
   b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
   c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
   d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.

7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

**POC Document Submission Requirements**

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

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

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

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

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

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

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

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

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

Conditions of Participation (CoPs)

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

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

The Division of Health Improvement (DHI) and the Developmental Disabilities Supports Division (DDSD) collaborated to revise the current Conditions of Participation (CoPs). There are seven Conditions of Participation in which providers must be in compliance.

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

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

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

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

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

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

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

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

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

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

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

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

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

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

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

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

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

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.
<table>
<thead>
<tr>
<th><strong>Agency:</strong></th>
<th>Zia Therapy Center, Inc. – Southwest Region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program:</strong></td>
<td>Developmental Disabilities Waiver</td>
</tr>
<tr>
<td><strong>Service:</strong></td>
<td>Community Living Supports (Family Living) and Community Inclusion Supports (Adult Habilitation, Community Access, Supported Employment)</td>
</tr>
<tr>
<td><strong>Monitoring Type:</strong></td>
<td>Routine Survey</td>
</tr>
<tr>
<td><strong>Survey Date:</strong></td>
<td>December 10 – 13, 2012</td>
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### CMS Assurance – Service Plans: ISP Implementation

Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.

<table>
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<tr>
<th><strong>Tag # 1A08</strong></th>
<th><strong>Agency Case File</strong></th>
<th><strong>Standard Level Deficiency</strong></th>
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<tbody>
<tr>
<td><strong>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</strong></td>
<td></td>
<td>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 10 individuals.</td>
</tr>
<tr>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</strong> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. <strong>D. Provider Agency Case File for the Individual:</strong> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual’s case file shall include the following requirements:</td>
<td><strong>Provider:</strong></td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td></td>
<td>Provider:</td>
<td>Enter your ongoing Quality Assurance/QI Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 6 of 10 individuals.

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

- Positive Behavioral Plan (#1)
- Occupational Therapy Plan (#7)
- Physical Therapy Plan (#6 & 7)
- Annual Physical (#2)
- Dental Exam
  - Individual #2 - As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found.
  - Individual #7 - As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found.
(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:

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<thead>
<tr>
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<tbody>
<tr>
<td>(a)</td>
<td>Complete file for the past 12 months;</td>
</tr>
<tr>
<td>(b)</td>
<td>ISP and quarterly reports from the current and prior ISP year;</td>
</tr>
<tr>
<td>(c)</td>
<td>Intake information from original admission to services; and</td>
</tr>
<tr>
<td>(d)</td>
<td>When applicable, the Individual Transition Plan at the time of discharge</td>
</tr>
</tbody>
</table>

- **Vision Exam**
  - Individual #8 - As indicated by collateral documentation reviewed, exam was scheduled for 11/27/2012. No evidence of exam results was found.
  - Individual #9 - As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of exam was found.

- **Dental Exam**
  - Individual #2 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.
  - Individual #7 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.
  - Individual #9 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.
from Los Lunas Hospital and Training School or Ft. Stanton Hospital.

**NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past.

**B. Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.
<table>
<thead>
<tr>
<th>Tag # 1A08.1</th>
<th>Agency Case File - Progress Notes</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| **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. | Based on record review, the Agency failed to maintain progress notes and other service delivery documentation for 3 of 10 Individuals. **Community Access Progress Notes/Daily Contact Logs**  
- Individual #3 - None found for 8/2012; 10/2012.  
- Individual #4 - None found for 8/2012 - 10/2012.  
- Individual #6 - None found for 8/2012; 9/2012. | State your Plan of Correction for the deficiencies cited in this tag here: →

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

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
<table>
<thead>
<tr>
<th>Tag # 1A32 &amp; 6L14</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Service Plan Implementation</td>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
<tr>
<td>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</td>
<td>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</td>
<td>Administrative Files Reviewed:</td>
<td></td>
</tr>
<tr>
<td>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on record review, the Agency failed to implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 7 of 10 individuals.</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
<tr>
<td></td>
<td>Per Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• None found for 8/2012; 9/2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Per Live Outcome; Actions Step for “Serve 24 meals to family,” is to be completed 1 time per week; evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• None found for 8/2012; 9/2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Per Work/Education/Volunteer Outcome; Actions Step for “Explore ways of increasing hours/Maintain current job,” were not completed at the required frequency for 11/2012.</td>
<td></td>
</tr>
</tbody>
</table>
play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

<table>
<thead>
<tr>
<th>Individual #</th>
<th>Per Work/Learn Outcome; Actions Step for “Become skilled on work ethics,” is to be completed 3 times per week; evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2012 - 10/2012.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Access Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Individual #1</td>
<td>Per Work/Education/Volunteer Outcome; Actions Steps for “Continue working as scheduled,” is to be completed 4 times per week; evidence found indicated it was not being completed at the required frequency indicated in the ISP for 11/2012.</td>
</tr>
<tr>
<td>Individual #3</td>
<td>None found for 8/2012; 10/2012.</td>
</tr>
<tr>
<td>Individual #4</td>
<td>None found for 8/2012 - 10/2012.</td>
</tr>
<tr>
<td>Individual #6</td>
<td>None found for 8/2012 - 10/2012.</td>
</tr>
<tr>
<td>Residential Files Reviewed:</td>
<td></td>
</tr>
<tr>
<td>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</td>
<td></td>
</tr>
<tr>
<td>Individual #10</td>
<td>Per Live Outcome; Actions Step for “Read 100 pages of a book,” per month is to be completed 2 times per week; evidence</td>
</tr>
</tbody>
</table>
found indicated it was not being completed at the required frequency as indicated in the ISP for 12/1/2012 - 12/10/2012.
<table>
<thead>
<tr>
<th>Tag # 5111 Reporting Requirements (Community Inclusion Quarterly Reports)</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS E. Provider Agency Reporting Requirements: All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual’s Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual’s action plan in the ISP; (3) Significant changes in the individual’s routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and…</td>
<td>Based on record review, the Agency failed to complete quarterly reports as required for 1 of 10 individuals receiving Community Inclusion services. <strong>Adult Habilitation Quarterly Reports</strong> • Individual #3 - None found for 2/2012 - 4/2012.</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here: → <strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.2.DDW.D1644.4.001.RTN.01.052

Page 19 of 69
### Tag # 5I22
#### SE Agency Case File

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency failed to maintain a confidential case file for each individual for 1 of 3 individuals receiving Supported Employment Services.</td>
</tr>
<tr>
<td>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td>- Vocational Assessment (#8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

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**Chapter 5 VII. Supported Employment Services Requirements**

**D. Provider Agency Requirements**

1. **Provider Agency Records:** The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDSD. Each individual’s earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual’s earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.

2. The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:

   - Quarterly progress reports;
   - Vocational assessments (A vocational assessment or profile is an objective analysis of a person’s interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDSD;
   - Career development plan as incorporated in the ISP; a career development plan consists of...
the vocational assessment and the ISP Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well as and a review and reporting mechanism for mutual accountability; and

(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.

New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy

Policy Title: Vocational Assessment Profile
Policy Eff July 16, 2008

I. PURPOSE
The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.

II. POLICY STATEMENT
Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.
<table>
<thead>
<tr>
<th>Tag # 6L14</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Case File</td>
<td>Based on record review, the Agency failed to maintain a complete and confidential case file in the residence for 4 of 4 Individuals receiving Family Living Services.</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>

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

- **Current Emergency & Personal Identification Information**
  - Did not contain Pharmacy Information (#5)

- **Annual ISP (#4, 10)**

- **Individual Specific Training Section of ISP (#4, 10)**

- **Positive Behavioral Plan (#10)**

- **Speech Therapy Plan (#10)**

- **Special Health Care Needs**
  - Nutritional Plan (#5)
  - Comprehensive Aspiration Risk Management Plan (#3)

- **Health Care Plans**
  - Weight/Body Mass Index (#4)
  - Bowel & Bladder (#4)

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Survey Report #: Q.13.2.DDW.D1644.4.001.RTN.01.052
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 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>Standard Level Deficiency</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
</table>
| 1A11.1 | Based on record review, the Agency failed to provide staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 15 of 52 Direct Support Personnel. No documented evidence was found of the following required training:  
- Transportation (DSP #43, 44, 45, 46, 51, 52, 55, 56, 62, 67, 68, 74, 75, 86, 91) | Provider: State your Plan of Correction for the deficiencies cited in this tag here: → | |
physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle)
5. Operating wheelchair lifts (if applicable to the staff's role)
6. Wheelchair tie-down procedures (if applicable to the staff's role)
7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)
| Tag # 1A20 Direct Support Personnel Training | Standard Level Deficiency |  |
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 | Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 20 of 52 Direct Support Personnel. |  |
| 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. | Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: |  |
| C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following: | • Pre- Service (DSP #55) |  |
| (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 | • Foundation for Health & Wellness (DSP #52, 55) |  |
| (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. | • Person-Centered Planning (1-Day) (DSP #40, 52, 55) |  |
| Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Provider: State your Plan of Correction for the deficiencies cited in this tag here: → | • First Aid (DSP #49, 52, 56, 73) |  |
| | • CPR (DSP #49, 50, 52, 56) |  |
| | • Assisting With Medication Delivery (DSP #41, 49, 52, 54, 55, 58, 66, 74, 75, 76, 82, 83, 84, 86, 88, 91) |  |
| | • Participatory Communication & Choice Making (DSP #55) |  |
| | • Rights & Advocacy (DSP #55) |  |
| | • Level 1 Health (DSP #55) |  |
| | • Positive Behavior Supports Strategies (DSP #55) |  |
| | • Teaching and Support Strategies (DSP #55) |  |
**Direct Service Agency Staff Policy - Eff. March 1, 2007**

**II. POLICY STATEMENTS:**

| A. | Individuals shall receive services from competent and qualified staff. |
| B. | Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. |
| C. | Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. |
| D. | Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. |
| E. | Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. |
| F. | Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. |
| G. | Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. |
| H. | Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. |
| I. | Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service. |
### Tag # 1A22

**Agency Personnel Competency**

<table>
<thead>
<tr>
<th>Condition of Participation Level</th>
<th>Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td></td>
</tr>
<tr>
<td>Based on interview, the Agency failed to ensure that training competencies were met for 3 of 6 Direct Support Personnel.</td>
<td></td>
</tr>
<tr>
<td><strong>When DSP were asked if they received training on the Individual’s ISP and what the plan covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSP #50 stated, “No. I can’t.” (Individual #4)</td>
<td></td>
</tr>
<tr>
<td><strong>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td>• DSP #50 stated, “Yes. Low sodium &amp; MR.”</td>
<td></td>
</tr>
<tr>
<td>As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration &amp; Oral Health (Individual #7)</td>
<td></td>
</tr>
<tr>
<td>• DSP #50 stated, “Hypothyroidism.” As indicated by the Agency file, the Individual has Health Care Plans for Weight/Body Mass Index and Bowel &amp; Bladder. (Individual #9)</td>
<td></td>
</tr>
<tr>
<td>• DSP #61 stated, “Respiratory &amp; Diabetes.” As indicated by the Agency file, the Individual has a Health Care Plan for Oral Hygiene (Individual #5)</td>
<td></td>
</tr>
<tr>
<td>• DSP #73 stated, “Constipation but it was discontinued last year.” As indicated by the</td>
<td></td>
</tr>
</tbody>
</table>

**Provider:**

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

Provider:

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

Provider:


communication system utilized by the individual;

(4) Direct service personnel shall meet the qualifications specified by DDSD in the Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators, Serving Individuals with Developmental Disabilities; and

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

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

<table>
<thead>
<tr>
<th>Electronic Comprehensive Health Assessment Tool, the Individual continues to require a Health Care Plan for Constipation (Individual #10)</th>
</tr>
</thead>
</table>

**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 #50 stated, “No, not to my knowledge.” As indicated by the Agency file and the Electronic Comprehensive Health Assessment Tool, the individual requires a Medical Emergency Response Plan for Aspiration. (Individual #7)
- DSP #50 stated, “Seizures.” As indicated by the Agency file, the Individual has a Medical Emergency Response Plan for Diabetes (Individual #9)
- DSP #73 stated, “No.” As indicated by the Individual Specific Training section of the ISP indicates the Individual requires Medical Emergency Response Plans for Allergies (Dilantin). (Individual #10)

**When DSP were asked, what steps are you to take in the event of medication dropped on the floor (contaminated medication), the following was reported:**

- DSP #61 stated, “Being a family provider it should be my decision to give it.” (Individuals #4 & 5) Per Agency Medication Delivery Policy 8.9.3 – 8.9.5 DSP are to “Place contaminated medication in a plastic bag labeled with the medication name, dose, quantity, date and their name. Fill out
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.

Medication Disposal Log form. Take medication to the Pharmacist and have them sign the Disposal form.”

When DSP were asked if the Individual had a Meal Time Plan and what the plan covered, the following was reported:

- DSP #50 stated, “No.” As indicated by the Individual Specific Training section of the ISP the individual has a Meal Time Plan. (Individual #7)
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
</table>
| **NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:**  
**A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner.  
**D. Training Documentation:** All licensed health care facilities and community based service providers shall prepare training documentation for each employee to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The licensed health care facility and community based service provider shall maintain documentation of an employee’s training for a period of at least twelve (12) months, or six (6) months after termination of an employee’s employment. Training curricula shall be kept on the provider premises and made available on request by the department. Training documentation shall be made available immediately upon a division representative’s request. Failure to provide employee training documentation shall subject the licensed health care facility or community based service provider to the penalties provided for in this rule.  
**Policy Title:** Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007  
**II. POLICY STATEMENTS:**  
A. Individuals shall receive services from | Based on record review and interview, the Agency failed to provide documentation verifying completion of Incident Management Training for 17 of 58 Agency Personnel.  
**Direct Support Personnel (DSP):**  
- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers’ Property) (DSP# 49, 50, 52, 53, 54, 55, 56, 66, 76, 83, 84, 87, 91)  
**Service Coordination Personnel (SC):**  
- Incident Management Training (Abuse, Neglect & Misappropriation of Consumers’ Property) (SC #92, 93, 97)  
**When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect & Misappropriation of Consumers’ Property, the following was reported:**  
- DSP #50 stated, “APS.” Staff was not able to identify the 2nd State Agency as DHI.  
- DSP #68 stated, “APS.” Staff was not able to identify the 2nd State Agency as DHI. |  
| **Provider:**  
State your Plan of Correction for the deficiencies cited in this tag here: → |  
Provider:  
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → |
competent and qualified staff.
C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
**Tag # 1A36
Service Coordination Requirements**

<table>
<thead>
<tr>
<th>Service Coordination Requirements</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to ensure that Orientation and Training requirements were met for 3 of 6 Service Coordinators.</td>
</tr>
<tr>
<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 Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:</td>
</tr>
<tr>
<td>C. Orientation and Training Requirements: Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:</td>
<td></td>
</tr>
<tr>
<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>• Pre-Service Manual (SC #93)</td>
</tr>
<tr>
<td><strong>NMAC 7.26.5.7 &quot;service coordinator&quot;:</strong> the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the Provider:</td>
<td></td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
</tr>
</tbody>
</table>


Survey Report #: Q.13.2.DDW.D1644.4.001.RTN.01.052
community service provider agency

NMAC 7.26.5.11 (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the individual’s progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more “key” community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDT’s selection are set forth as follows:

(i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations;
(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;
(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;
(iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;
<table>
<thead>
<tr>
<th>Tag # 1A37</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Specific Training</td>
<td>Based on record review, the Agency failed to ensure that Individual Specific Training requirements were met for 12 of 58 Agency Personnel. Review of personnel records found no evidence of the following:</td>
</tr>
</tbody>
</table>

**Direct Support Personnel (DSP):**
- Individual Specific Training (DSP #41, 44, 45, 55, 58, 59, 61, 72, 79, 87)

**Service Coordination Personnel (SC):**
- Individual Specific Training (SC #94, 97)

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

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

---

**Tag # 1A37**

**Individual Specific Training**


**CHAPTER 1 IV. GENERAL REQUIREMENTS FOR PROVIDER AGENCY SERVICE PERSONNEL:** The objective of this section is to establish personnel standards for DD Medicaid Waiver Provider Agencies for the following services: Community Living Supports, Community Inclusion Services, Respite, Substitute Care and Personal Support Companion Services. These standards apply to all personnel who provide services, whether directly employed or subcontracting with the Provider Agency. Additional personnel requirements and qualifications may be applicable for specific service standards.

**C. Orientation and Training Requirements:**

Orientation and training for direct support staff and his or her supervisors shall comply with the DDSD/DOH Policy Governing the Training Requirements for Direct Support Staff and Internal Service Coordinators Serving Individuals with Developmental Disabilities to include the following:

1. **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.

**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.
### 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

| CHAPER 1 I. PROVIDER AGENCY ENROLLMENT PROCESS |
| Provider: State your Plan of Correction for the deficiencies cited in this tag here: → |

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency had not fully implemented their Continuous Quality Management System as required by standard and DOH Provider Agreement.</td>
</tr>
<tr>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
</tr>
</tbody>
</table>

**Provider:**

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

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Survey Report #: Q.13.2.DDW.D1644.4.001.RTN.01.052

Page 38 of 69
(4) Trends in medication and medical incidents 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
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(4)</td>
<td>Services must have a designated incident management coordinator in place; 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.</td>
<td></td>
</tr>
</tbody>
</table>
Tag # 1A05

General Requirements


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

A. General Requirements:

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

Based on record review, the Agency failed to develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures.

Review of Agency policies and procedures found the following:

No evidence of the following policies and procedures:

- Nursing On-Call

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

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
<table>
<thead>
<tr>
<th>Tag # 1A09</th>
<th>Medication Delivery (MAR) - Routine Medication</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Medication Administration Records (MAR) were reviewed for the months of September, October, November and December 2012.</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS</strong>: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</td>
<td>Based on record review, 2 of 10 individuals had Medication Administration Records, which contained missing medications entries and/or other errors:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td><strong>E. Medication Delivery</strong>: 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.</td>
<td>Individual #3 October 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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;</td>
<td>• Lamotrigine 100mg (2 times daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Prescribed dosage, frequency and</td>
<td>November 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lamotrigine 100mg (2 times daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual #5 September 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>As indicated by the Medication Administration Records Clindamycin 1% gel is to be applied twice daily. Documentation on the Medication Administration Record indicated the medication was administered 1 time daily 9/1 – 9/30.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication Administration Records did not contain the route of administration for the following medications:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Partoprazole 40mg (1 time daily)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
method/route of administration, times and dates of administration;
(c) Initials of the individual administering or assisting with the medication;
(d) Explanation of any medication irregularity;
(e) Documentation of any allergic reaction or adverse medication effect; and
(f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

(3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose;
(4) MARs are not required for individuals participating in Independent Living who self-administer their own medications;
(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;

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

(d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications.
This documentation shall include:

(i) Name of resident;
(ii) Date given;
(iii) Drug product name;
(iv) Dosage and form;
(v) Strength of drug;
(vi) Route of administration;
(vii) How often medication is to be taken;
(viii) Time taken and staff initials;
(ix) Dates when the medication is discontinued or changed;
(x) The name and initials of all staff administering medications.

Model Custodial Procedure Manual
D. Administration of Drugs

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

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

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.
<table>
<thead>
<tr>
<th>Tag # 1A09.1</th>
<th>Medication Delivery - PRN Medication</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Medication Administration Records (MAR) were reviewed for the months of September, October, November and December 2012.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here: →</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Based on record review, 1 of 10 individuals had PRN Medication Administration Records, which contained missing elements as required by standard:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Individual #3 November 2012 No evidence of documented Signs/Symptoms were found for the following PRN medication:</td>
<td>Provider:</td>
<td></td>
</tr>
<tr>
<td>(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:</td>
<td>• Albuterol 0.83% – PRN – 11/25, 26, 27, 28, 29, 30 (given 2 times daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(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;</td>
<td>No Effectiveness was noted on the Medication Administration Record for the following PRN medication:</td>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →</td>
<td></td>
</tr>
<tr>
<td>(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;</td>
<td>• Albuterol 0.83% – PRN – 11/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30 (given 2 times daily)</td>
<td>}</td>
<td></td>
</tr>
<tr>
<td>(c)</td>
<td>Initials of the individual administering or assisting with the medication;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d)</td>
<td>Explanation of any medication irregularity;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e)</td>
<td>Documentation of any allergic reaction or adverse medication effect; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f)</td>
<td>For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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;
   (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.).
<table>
<thead>
<tr>
<th>Tag # 1A15.1 Nurse Availability</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
</table>
| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 Chapter 1. III. E. (1 - 4) CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION | Based on interview, the Agency failed to ensure nursing services were available as needed for 2 of 10 individuals. **When Direct Service Professionals (DSP) were asked about the availability of their agency nurse, the following was reported:**  
- DSP #61 stated, "I don't know if they have a nurse full-time. I would call the Agency and leave a message. I don’t think she's full-time." (Individual #4 & 5) | **State your Plan of Correction for the deficiencies cited in this tag here:** → |
| NEW MEXICO NURSING PRACTICE ACT CHAPTER 61, ARTICLE 3 I. "licensed practical nursing" means the practice of a directed scope of nursing requiring basic knowledge of the biological, physical, social and behavioral sciences and nursing procedures, which practice is at the direction of a registered nurse, physician or dentist licensed to practice in this state. This practice includes but is not limited to:  
(1) contributing to the assessment of the health status of individuals, families and communities;  
(2) participating in the development and modification of the plan of care;  
(3) implementing appropriate aspects of the plan of care commensurate with education and verified competence;  
(4) collaborating with other health care professionals in the management of health care; and  
(5) participating in the evaluation of responses to interventions; | **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here:** → |


Survey Report #: Q.13.2.DDW.D1644.4.001.RTN.01.052
<table>
<thead>
<tr>
<th>Tag # 1A15.2 &amp; 5I09</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Documentation Requirements</td>
<td>Based on record review, the Agency failed to maintain the required documentation in the Individuals Agency Record as required per standard for 7 of 10 individuals.</td>
</tr>
<tr>
<td></td>
<td>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</td>
</tr>
<tr>
<td></td>
<td>• Medication Administration Assessment Tool (#{8})</td>
</tr>
<tr>
<td></td>
<td>• Healthcare Passport (#2, 3, 8, 9)</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive Aspiration Risk Management Plan (#3)</td>
</tr>
<tr>
<td></td>
<td>• Aspiration Risk Screening Tool (#1, 8)</td>
</tr>
<tr>
<td></td>
<td>• Quarterly Nursing Review of HCP/Medical Emergency Response Plans:</td>
</tr>
<tr>
<td></td>
<td>◦ None found for 11/2011 – 11/2012 (#3)</td>
</tr>
<tr>
<td></td>
<td>• Health Care Plans</td>
</tr>
<tr>
<td></td>
<td>◦ Weight/Body Mass Index</td>
</tr>
<tr>
<td></td>
<td>◦ Individual #1 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
<tr>
<td></td>
<td>◦ GI/Constipation</td>
</tr>
<tr>
<td></td>
<td>◦ Individual #6 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.</td>
</tr>
</tbody>
</table>

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

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
assessments in lieu of the agency nurse. Agency nurses may also complete these assessments in collaboration with the Primary Care Practitioner if they believe such consultation is necessary for an accurate assessment. Family Living Provider Agencies have the option of having the subcontracted caregiver complete the HAT instead of the nurse or PCP, if the caregiver is comfortable doing so. However, the agency nurse must be available to assist the caregiver upon request. (c) For newly allocated individuals, the HAT and the MAAT must be completed within seventy-two (72) hours of admission into direct services or two weeks following the initial ISP, whichever comes first. (d) For individuals already in services, the HAT and the MAAT must be completed at least fourteen (14) days prior to the annual ISP meeting and submitted to all members of the interdisciplinary team. The HAT must also be completed at the time of any significant change in clinical condition and upon return from any hospitalizations. In addition to annually, the MAAT must be completed at the time of any significant change in clinical condition, when a medication regime or route change requires delivery by licensed or certified staff, or when an individual has completed additional training designed to improve their skills to support self-administration (see DDSD Medication Assessment and Delivery Policy). (e) Nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective

- **Skin & Wound**
  - Individual #6 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- **Bowel & Bladder**
  - Individual #6 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- **Pain**
  - Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

- **Anxiety**
  - Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.

- **Medical Emergency Response Plans**
- **Seizures**
  - Individual #1 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- **Diabetes**
  - Individual #1 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.

- **Neuro/Shunt**
  - Individual #1 - According to Electronic Comprehensive Heath Assessment Tool the individual is required to have a plan. No evidence of a plan found.
information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants.

(2) Health related plans
(a) For individuals with chronic conditions that have the potential to exacerbate into a life-threatening situation, a medical crisis prevention and intervention plan must be written by the nurse or other appropriately designated healthcare professional. 
(b) Crisis prevention and intervention plans must be written in user-friendly language that is easily understood by those implementing the plan. 
(c) The nurse shall also document training regarding the crisis prevention and intervention plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. 
(d) If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for crisis prevention and intervention plans to assure maximum consistency across settings.
(3) For all individuals with a HAT score of 4, 5 or 6, the nurse shall develop a comprehensive healthcare plan that includes health related supports identified in the ISP (The healthcare plan is the equivalent of a nursing care plan; two separate documents are not required nor recommended):
(a) Each healthcare plan must include a statement of the person’s healthcare needs 

- **Allergy to Dilantin**
  - Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found.
and list measurable goals to be achieved through implementation of the healthcare plan. Needs statements may be based upon supports needed for the individual to maintain a current strength, ability or skill related to their health, prevention measures, and/or supports needed to remediate, minimize or manage an existing health condition.

(b) Goals must be measurable and shall be revised when an individual has met the goal and has the potential to attain additional goals or no longer requires supports in order to maintain the goal.

c) Approaches described in the plan shall be individualized to reflect the individual’s unique needs, provide guidance to the caregiver(s) and designed to support successful interactions. Some interventions may be carried out by staff, family members or other team members, and other interventions may be carried out directly by the nurse – persons responsible for each intervention shall be specified in the plan.

(d) Healthcare plans shall be written in language that will be easily understood by the person(s) identified as implementing the interventions.

(e) The nurse shall also document training on the healthcare plan delivered to agency staff and other team members, clearly indicating competency determination for each trainee. If the individual receives services from separate agencies for community living and community inclusion services, nurses from each agency shall collaborate in the development of and training delivery for healthcare plans to assure maximum consistency across settings.

(f) Healthcare plans must be updated to reflect relevant discharge orders whenever an individual returns to services following a
hospitalization.
(g) All crisis prevention and intervention plans and healthcare plans shall include the individual’s name and date on each page and shall be signed by the author.
(h) Crisis prevention and intervention plans as well as healthcare plans shall be reviewed by the nurse at least quarterly, and updated as needed.

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

CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS
B. IDT Coordination
(1) Community Inclusion Services Provider Agencies shall participate on the IDT as specified in the ISP Regulations (7.26.5 NMAC), and shall ensure direct support staff participation as needed to plan effectively for the individual; and
(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.

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

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

1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.
Tag # 6L13
Community Living Healthcare Reqts.


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.

(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 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 3 of 4 individuals receiving Community Living Services.

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

- **Annual Physical (#3, 4)**

- **Dental Exam**
  - Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.

- **Vision Exam**
  - Individual #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
  - Individual #10 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.

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

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


Survey Report #: Q.13.2/DDW.D1644.4.001.RTN.01.052
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...
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.
<table>
<thead>
<tr>
<th>Tag # 6L25 Residential Health &amp; Safety (Supported Living &amp; Family Living)</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here: →</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on observation, the Agency failed to ensure that each individual's residence met all requirements within the standard for 3 of 3 Family Living residences.</td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS</td>
<td>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</td>
<td></td>
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<tr>
<td>L. Residence Requirements for Family Living Services and Supported Living Services</td>
<td><strong>Family Living Requirements:</strong></td>
<td></td>
</tr>
<tr>
<td>(1) Supported Living Services and Family Living Services providers shall assure that each individual’s residence has:</td>
<td>• Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#3, 4, 5, 10)</td>
<td></td>
</tr>
<tr>
<td>(a) Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence;</td>
<td>• Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP (#3, 10)</td>
<td></td>
</tr>
<tr>
<td>(b) General-purpose first aid kit;</td>
<td>• Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3, 4, 5, 10)</td>
<td></td>
</tr>
<tr>
<td>(c) When applicable due to an individual’s health status, a blood borne pathogens kit;</td>
<td><strong>Note:</strong> Individuals 4 &amp; 5 live in the same residence.</td>
<td></td>
</tr>
<tr>
<td>(d) Accessible written procedures for emergency evacuation e.g. fire and weather-related threats;</td>
<td></td>
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<tr>
<td>(e) Accessible telephone numbers of poison control centers located within the line of sight of the telephone;</td>
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<tr>
<td>(f) Accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills shall occur at least once a year during each shift;</td>
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</tr>
<tr>
<td>(g) Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual’s ISP; and</td>
<td></td>
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<tr>
<td>(h) Accessible written procedures for emergency placement and relocation of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on observation, the Agency failed to ensure that each individual’s residence met all requirements within the standard for 3 of 3 Family Living residences.</td>
<td></td>
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</tbody>
</table>
individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.
### Standard of Care

| Tag # | 5I44 | Adult Habilitation Reimbursement
|-------|------|----------------------------------|

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

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

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

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

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

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

**8.314.1 BI RECORD KEEPING AND**

### Deficiencies

Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 7 of 10 individuals.

**Individual #1 August 2012**
- The Agency billed 67 units of Adult Habilitation (T2021 U2) from 8/6/2012 through 8/10/2012. Documentation received accounted for 50 units.
- The Agency billed 43 units of Adult Habilitation (T2021 U2) from 8/13/2012 through 8/16/2012. Documentation received accounted for 40 units.

**Individual #3 August 2012**
- The Agency billed 22 units of Adult Habilitation (T2021 U2) on 8/31/2012. Documentation received accounted for 20 units.

**October 2012**
- The Agency billed 63 units of Adult Habilitation (T2021 U2) from 10/11/2012 through 10/12/2012. Documentation received accounted for 55 units.
- The Agency billed 41 units of Adult

### Agency Plan of Correction, On-going QA/QI & Responsible Party

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

**Provider:**
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →
DOCUMENTATION REQUIREMENTS:
Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.


CHAPTER 5 XVI. REIMBURSEMENT

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

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

(2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours.

Habilitation (T2021 U2) from 10/18/2012 through 10/19/2012. Documentation received accounted for 39 units.

Individual #6
August 2012
- The Agency billed 30 units of Adult Habilitation (T2021 U2) from 8/13/2012 through 8/14/2012. Documentation received accounted for 24 units.
- The Agency billed 120 units of Adult Habilitation (T2021 U2) from 8/27/2012 through 8/31/2012. Documentation received accounted for 116 units.

Individual #7
August 2012
- The Agency billed 49 units of Adult Habilitation (T2021 U1) from 8/28/2012 through 8/30/2012. Documentation received accounted for 46 units.

October 2012
- The Agency billed 39 units of Adult Habilitation (T2021 U2) from 10/9/2012 through 10/11/2012. Documentation received accounted for 18 units.

Individual #8
August 2012
- The Agency billed 60 units of Adult Habilitation (T2021 U2) from 8/20/2012 through 8/23/2012. Documentation received accounted for 57 units.

October 2012
- The Agency billed 29 units of Adult Habilitation (T2021 U2) from 10/22/2012.
through 10/23/2012. Documentation received accounted for 26 units.

Individual #9
October 2012
  • The Agency billed 72 units of Adult Habilitation (T2021 U2) from 10/29/2012 through 10/31/2012. Documentation received accounted for 65 units.

Individual #10
August 2012
  • The Agency billed 24 units of Adult Habilitation (T2021 U2) on 8/15/2012. Documentation received accounted for 22 units.

October 2012
  • The Agency billed 91 units of Adult Habilitation (T2021 U2) from 10/23/2012 through 10/26/2012. Documentation received accounted for 85 units.
<table>
<thead>
<tr>
<th>Tag # 6L27   Family Living Reimbursement</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</td>
<td>Based on record review, the Agency failed to provide written or electronic documentation as evidence for each unit billed for Family Living Services for 3 of 4 individuals.</td>
</tr>
<tr>
<td>CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION</td>
<td></td>
</tr>
<tr>
<td>A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.</td>
<td></td>
</tr>
<tr>
<td>B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:</td>
<td></td>
</tr>
<tr>
<td>(1) Date, start and end time of each service encounter or other billable service interval;</td>
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</tr>
<tr>
<td>(2) A description of what occurred during the encounter or service interval; and</td>
<td></td>
</tr>
<tr>
<td>(3) The signature or authenticated name of staff providing the service.</td>
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</tr>
</tbody>
</table>

**MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or

**Individual #4**

**August 2012**

- The Agency billed 28 units of Family Living (T2033) from 8/1/2012 through 8/28/2012. Documentation did not contain the required elements on 8/1/2012 through 8/28/2012. Documentation received accounted for 0 units. The following element was not met:
  - Start and end time of each service encounter or other billable service interval.

**September 2012**

- The Agency billed 28 units of Family Living (T2033) from 9/1/2012 through 9/30/2012. Documentation did not contain the required elements on 9/1/2012 through 9/30/2012. Documentation received accounted for 0 units. The following element was not met:
  - Start and end time of each service encounter or other billable service interval (9/1 – 28);

**Individual #5**

**August 2012**

- The Agency billed 29 units of Family Living (T2033) from 8/1/2012 through 8/29/2012. Documentation did not contain the required elements on 8/1/2012 through 8/29/2012. Documentation received accounted for 0 units. The following element was not met:
  - Start and end time of each service encounter or other billable service interval.

**Provider:**

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

**Provider:**

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

CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES

B. Reimbursement for Family Living Services

(1) Billable Unit: The billable unit for Family Living Services is a daily rate for each individual in the residence. A maximum of 340 days (billable units) are allowed per ISP year.

(2) Billable Activities shall include:
   (a) Direct support provided to an individual in the residence any portion of the day;
   (b) Direct support provided to an individual by the Family Living Services direct support or substitute care provider away from the residence (e.g., in the community); and
   (c) Any other activities provided in accordance with the Scope of Services.

(3) Non-Billable Activities shall include:
   (a) The Family Living Services Provider Agency may not bill for room and board;
   (b) Personal care, nutritional counseling and nursing supports may not be billed as separate services for an individual receiving Family Living Services; and
   (c) Family Living services may not be billed for the same time period as Respite.
   (d) The Family Living Services Provider Agency may not bill on days when an individual is hospitalized or in an institutional care setting. For this

<table>
<thead>
<tr>
<th>September 2012</th>
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<tbody>
<tr>
<td>The Agency billed 28 units of Family Living (T2033) from 9/1/2012 through 9/28/2012. Documentation did not contain the required elements on 9/1/2012 through 9/28/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Start and end time of each service encounter or other billable service interval (9/1 – 28);</td>
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</tbody>
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<thead>
<tr>
<th>Individual #10</th>
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<tbody>
<tr>
<td>September 2012</td>
</tr>
<tr>
<td>The Agency billed 28 units of Family Living (T2033) from 9/2/2012 through 9/29/2012. Documentation did not contain the required elements on 9/2/2012 through 9/29/2012. Documentation received accounted for 0 units. The following element was not met: ➢ Start and end time of each service encounter or other billable service interval.</td>
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<table>
<thead>
<tr>
<th>October 2012</th>
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</thead>
<tbody>
<tr>
<td>The Agency billed 28 units of Family Living (T2033) from 10/1/2012 through 10/28/2012. Documentation did not contain the required elements 10/1/2012 through 10/24/2012. Documentation received accounted for 4 units. One or more of the following elements was not met: ➢ Start and end time of each service encounter or other billable service interval (10/1 – 20; 10/23 &amp; 24);</td>
</tr>
</tbody>
</table>
purpose a day is counted from one midnight to the following midnight.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 - Chapter 6 - COMMUNITY LIVING SERVICES

III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES

C. Service Limitations. Family Living Services cannot be provided in conjunction with any other Community Living Service, Personal Support Service, Private Duty Nursing, or Nutritional Counseling. In addition, Family Living may not be delivered during the same time as respite; therefore, a specified deduction to the daily rate for Family Living shall be made for each unit of respite received.


SUBSTITUTE CARE means the provision of family living services by an agency staff or subcontractor during a planned/scheduled or emergency absence of the direct service provider.

RESPITE means a support service to allow the primary caregiver to take a break from care giving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.
Date: April 8, 2013

To: Peggy Denson, Chief Executive Officer
Provider: Zia Therapy Center, Inc.
Address: 900 1st Street
State/Zip: Alamogordo, New Mexico 88310
E-mail Address: denson@ziatherapy.org

Region: Southwest
Survey Date: December 10 – 13, 2012
Program Surveyed: Developmental Disabilities Waiver

RE: Request for an Informal Reconsideration of Findings

Dear Ms. Denson;

Your request for a Reconsideration of Findings was received on March 6, 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 # 1A36
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, deficiencies noted in tag 1A36 regarding Staff #96 will be removed; the remainder of the deficiencies were not disputed. The remaining citations noted in this tag were not disputed.

Regarding Tag # 5I44
Determination: The IRF committee is upholding 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, deficiencies noted in tag 5I44 were re-calculated and it was determined the acceptable units do not equal the 39 units billed for. Furthermore, only units for 10/10/12 were supplied as evidence in this IRF, the original citation was for the date range 10/9 to 10/12, 2012. The remaining citations noted in this tag 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
Dear Ms. Denson;

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.**

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

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

Consistent use 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

Q.13.4/DDW.D1644.4.001.RTN.09.127