Dear Ramon V. Chavez;

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**
The following tags are identified as Condition of Participation Level Deficiencies:
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A25 Caregiver Criminal History Screening
Tag #1A31 Client Rights/Human Rights

This determination is based on noncompliance 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.

During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to Attachment A for specific instruction on completing your Plan of Correction. At a minimum your Plan of Correction should address the following for each Tag cited:

Corrective Action:
- How is the deficiency going to be corrected? (i.e. obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:
- What is going to be done? (i.e. file reviews, periodic check with checklist, etc.)
- How many individuals is this going to effect? (i.e. percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e. weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position)
- What steps will be taken if issues are found? (i.e. retraining, requesting documents, filing RORI, etc.)

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: Amanda Castaneda, Plan of Correction Coordinator
   1170 North Solano Suite D Las Cruces, New Mexico 88001

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.

Billing Deficiencies:
If you have deficiencies noted in this report of findings under the Service Domain: Medicaid Billing/Reimbursement, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, though this is not the preferred method of payment. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: Lisa Medina-Lujan

QMB Report of Findings – Nezzy Care of Las Cruces – Southwest & Southeast Regions – May 05 - 11, 2017

Survey Report #: Q.17.4.DDW.52981878.3/4.RTN.01.17.255
Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

**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 Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 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,

*Tricia Hart, AAS*  
Tricia Hart, AAS  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau
Survey Process Employed:

Administrative Review Start Date: May 05, 2017

Contact: **Agency Name**
Raymond Chavez, Executive Director

**DOH/DHI/QMB**
Tricia Hart, AAS, Team Lead/Healthcare Surveyor

On-site Entrance Conference Date: May 08, 2017

Present: **Nezzy Care of Las Cruces (Mayfield-Colt Corporation)**
Raymond Chavez, Executive Director
Jody Howard, Agency Nurse
Laurie Ortega, Service Coordinator
Yvonne Ramos, Service Coordinator
Keith Cline, Service Coordinator / Incident Management Coordinator

**DOH/DHI/QMB**
Tricia Hart, AAS, Team Lead/Healthcare Surveyor
Debbie Russell, BS, Healthcare Surveyor

Exit Conference Date: May 11, 2017

Present: **Nezzy Care of Las Cruces (Mayfield-Colt Corporation)**
Raymond Chavez, Executive Director
Vanessa Chavez, Manager

**DOH/DHI/QMB**
Tricia Hart, AAS, Team Lead/Healthcare Surveyor
Debbie Russell, BS, Healthcare Surveyor
Kandis Gomez, AA, Healthcare Surveyor
Barbara Kane, BAS, Healthcare Surveyor
Chris Melon, MPA, Healthcare Surveyor

**DDSD Regional Office**
Jeanna Caruthers, Regional Manager (Southwest Region)

Administrative Locations Visited 1

Total Sample Size 18

2 - Jackson Class Members
16 - Non-Jackson Class Members

6 - Supported Living
7 - Family Living
2 - Adult Habilitation
12 - Customized Community Supports
5 - Community Integrated Employment Services
4 - Customized In-Home Supports

Total Homes Visited 11

- Supported Living Homes Visited 5
Note: The following Individuals share a SL residence:
➢ #7, 15

- Family Living Homes Visited 6 (One Family Living home was not visited during the on-site survey)

Persons Served Records Reviewed 18
Persons Served Interviewed 5
Persons Served Observed 13 (Individuals chose not to participate in the interview process)
Direct Support Personnel Interviewed 25 (Two Substitute Care/Respite Personnel interviewed as DSP)
Direct Support Personnel Records Reviewed 77
Substitute Care/Respite Personnel Records Reviewed 18
Service Coordinator Records Reviewed 4
Administrative Interviews 2 (One Service Coordinator also performs duties as the Incident Management Coordinator)

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 / General Events Reports
- 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
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 deficiencies and non-compliance.

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD 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 six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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.

The following details should be considered when developing your Plan of Correction:
• 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, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
• How accuracy in Billing/Reimbursement documentation is assured;
• How health, safety is assured;
• For Case Management Providers, how Individual Specific Plans 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 indicators; 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 must 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 POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
   - Electronically at AmandaE.Castaneda@state.nm.us (preferred method)
   - Fax to 575-528-5019, or
   - Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
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 “approved” 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.
   e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
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. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents 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. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings.

Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator, 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.
Attachment B

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

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

The QMB Determination of Compliance process is based on 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 the following Service Domains.

Case Management Services (Four Service Domains):
- Plan of Care: ISP Development & Monitoring
- Level of Care
- Qualified Providers
- Health, Safety and Welfare

Community Living Supports / Inclusion Supports (Three Service Domains):
- Service Plans: ISP Implementation
- Qualified Provider
- Health, Safety and Welfare

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: Plan of Care ISP Development & Monitoring**

Condition of Participation:
1. **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:
2. **ISP Monitoring and Evaluation**: The Case Manager shall ensure the health and welfare of the individual through monitoring the implementation of ISP desired outcomes.

**Service Domain: Level of Care**

Condition of Participation:
3. **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.

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: Service Plan: ISP Implementation**

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

**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 and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

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.
Attachment C

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

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

Instructions:
1. The Informal Reconsideration of the Finding (IRF) request must be 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 IRF process, email the IRF Chairperson, Crystal Lopez-Beck at Crystal.Lopez-Beck@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.
### Agency:
**Nezzy Care of Las Cruces (Mayfield-Colt Corporation) - Southwest and Southeast Regions**

**Program:** Developmental Disabilities Waiver  
**Service:**  
- **2007:** Supported Living, Family Living, and Adult Habilitation  
- **2012:** Supported Living, Family Living, Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports

**Survey Type:** Routine Survey  
**Survey Date:** May 05 - 11, 2017

#### Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI & Responsible Party | Date Due
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Domain: Service Plans: ISP Implementation</strong></td>
<td><strong>Deficiencies</strong></td>
<td><strong>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</strong></td>
<td><strong>Date Due</strong></td>
</tr>
</tbody>
</table>

**Tag # 1A08.1 Agency Case File - Progress Notes**

Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 2 of 18 Individuals.

Review of the Agency individual case files revealed the following items were not found:

**Family Living Progress Notes/Daily Contact Logs**
- Individual #10 - None found for 1/23 – 24, 2017.

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →

---

Survey Report #: Q.17.4.DDW.52981878.3/4.RTN.01.17.255

Provider Agencies must maintain all records necessary to fully disclose the service, quality. The documentation of the billable time spent with an individual shall be kept on the written or electronic record.

### Chapter 12 (SL) 3. Agency Requirements:

2. Reimbursement A. 1. Provider Agencies must maintain all records necessary to fully disclose the service, quality. The documentation of the billable time spent with an individual shall be kept on the written or electronic record.

### Chapter 13 (IMLS) 3. Agency Requirements:

4. Reimbursement A. 1. Provider Agencies must maintain all records necessary to fully disclose the service, quality. The documentation of the billable time spent with an individual shall be kept on the written or electronic record.

### Chapter 15 (ANS) 4. Reimbursement A. 1.

Provider Agencies must maintain all records necessary to fully disclose the service, quality. The documentation of the billable time spent with an individual shall be kept on the written or electronic record.

---


**CHAPTER 1 II. PROVIDER AGENCY Requirements: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the
receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

(3) Progress notes and other service delivery documentation;
<table>
<thead>
<tr>
<th>Tag # 1A32 and LS14 / 6L14</th>
<th>Individual Service Plan Implementation</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tag # 1A32 and LS14 / 6L14</strong></td>
<td><strong>Individual Service Plan Implementation</strong></td>
<td><strong>Standard Level Deficiency</strong></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
<tr>
<td><strong>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</strong> 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>Based on record review, the Agency did not 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 4 of 18 individuals.</td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</td>
<td></td>
<td><strong>Provider:</strong> State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
<tr>
<td></td>
<td><strong>Administrative Files Reviewed:</strong></td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td><strong>Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td>Individual #5</td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td>• According to the Live Outcome; Action Step for &quot;...will change the channel on the TV&quot; 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 1/2017 - 3/2017.</td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td>Individual #10</td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td>• None found regarding: Live Outcome/Action Step: &quot;... will follow the visual sequence schedule&quot; for 1/2017 - 3/2017. Action step is to be completed 1 time per week.</td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td><strong>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</strong></td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td>Individual #18</td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td></td>
<td>• None found regarding: Work/learn Outcome/Action Step: &quot;... will clean tables&quot;</td>
<td></td>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
</tbody>
</table>
direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recomplied 10/31/01]

for 1/2017. Action step is to be completed 1 time per month.

Residential Files Reviewed:

Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes

Individual #5
- None found regarding: Live Outcome/Action Step: “…. will need assistive technology (remote)” for 5/1 – 5, 2017. Action Step is to be completed 1 time per week.

- None found regarding: Live Outcome/Action Step: “…. will change the channel on the T.V.” for 5/1 – 5, 2017. Action Step is to be completed 1 time per week.

Individual #14
- None found regarding: Live Outcome/Action Step: “…. will work the flowers and plants at her home” for 5/1- 5, 2017. Action Step is to be completed 1 time per week.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>LS14 / 6L14</th>
<th>Residential Case File</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</td>
<td>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 12 Individuals receiving Family Living Services and Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
</tbody>
</table>
|       |             | CHAPTER 11 (FL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual’s home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. | Current Emergency and Personal Identification Information:  
- Did not contain current address (#8, 16) | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → |
|       |             | CHAPTER 12 (SL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual’s home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. | Annual ISP:  
- Not current (#2) | |
|       |             | CHAPTER 13 (IMLS) 2. Service Requirements B.1. Documents to Be Maintained in The Home:  
a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access;  
b. Personal identification;  
c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable;  
d. Dated and signed consent to release information forms as applicable;  
e. Current orders from health care practitioners;  
f. Documentation and maintenance of accurate medical history in Therap website; | Individual Specific Training Section of ISP (formerly Addendum B):  
- Not found (#2)  
- Incomplete (#3) | |
|       |             | ISP Teaching and Supports Strategies:  
- Individual #5 - TSS not found for the following Action Steps:  
  - Live Outcome Statement:  
    - “…will need assistive technology (remote).”  
    - “…will change the channel on the TV.”  
|       |             | Individual #14 - TSS not found for the following Action Steps:  
  - Live Outcome Statement:  
    - “…will work the flowers and plants at her home.” | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → |
|       |             | Individual #15 - TSS not found for the following Action Steps: | Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): → |
g. Medication Administration Records for the current month;

h. Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided;
i. Progress notes written by DSP and nurses;
j. Documentation and data collection related to ISP implementation;
k. Medicaid card;
l. Salud membership card or Medicare card as applicable; and
m. A Do Not Resuscitate (DNR) document and/or Advanced Direc
tives as applicable.

DEVELOPMENTAL DISABILITIES SUPPORTS
DIVISION (DDSD): Director's Release:
Consumer Record Requirements eff. 11/1/2012

III. Requirement Amendments(s) or
Clarifications:
A. All case management, living supports,
customized in-home supports, community
integrated employment and customized
community supports providers must maintain
records for individuals served through DD Waiver
in accordance with the Individual Case File Matrix
incorporated in this director's release.

H. Readily accessible electronic records are
accessible, including those stored through the
Therap web-based system.

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

CHAPTER 6. VIII. COMMUNITY LIVING
SERVICE PROVIDER AGENCY
REQUIREMENTS
A. Residence Case File: For individuals
receiving Supported Living or Family Living, the
Agency shall maintain in the individual’s home a
complete and current confidential case file for

- Live Outcome Statement:
  - “…will make a list and purchase
    ingredients.”
  - “…will assist with making a dish.”

Speech Therapy Plan:
- Not found (#15)

Occupational Therapy Plan:
- Not found (#3, 15)

Comprehensive Aspiration Risk Management
Plan
- Not Found (#15)

Progress Notes/Daily Contacts Logs:
- Individual #5 - None found for 5/8 – 9,
  2017.
- Individual #14 - None found for 5/6 – 9,
  2017.
each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:

1. Complete and current ISP and all supplemental plans specific to the individual;
2. Complete and current Health Assessment Tool;
3. Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan;
4. Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office);
5. Data collected to document ISP Action Plan implementation;
6. Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month;
7. Physician's or qualified health care providers written orders;
8. Progress notes documenting implementation of a physician's or qualified health care provider's order(s);
9. Medication Administration Record (MAR) for the past three (3) months which includes:
   a. The name of the individual;
(b) A transcription of the healthcare practitioner’s 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

**Service Domain: 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.

### Deficiencies

<table>
<thead>
<tr>
<th>Tag # 1A11.1 Transportation Training</th>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy <strong>Eff. Date:</strong> March 1, 2007</td>
<td></td>
</tr>
<tr>
<td>Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 5 of 77 Direct Support Personnel.</td>
<td></td>
</tr>
</tbody>
</table>

**No documented evidence was found of the following required training:**

- Transportation (#571, 573, 577)

When DSP were asked if they had received transportation training including training on the agency’s policies and procedures following was reported:

- DSP #525 stated, “No, I don’t think so.”
- DSP #594 stated, “No.”

**NMAC 7.9.2 F. TRANSPORTATION:** (1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any resident. The passenger transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of the vehicle, assisting passengers, and safe lifting procedures.

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →
operation of equipment, familiarity with state regulations governing the transportation of persons with disabilities, and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.

(2) Any employee or agent of a regulated facility or agency who drives a motor vehicle provided by the facility or agency for use in the transportation of clients must complete:

(a) A state approved training program in passenger assistance and

(b) A state approved training program in the operation of a motor vehicle to transport clients of a regulated facility or agency. The motor vehicle transportation assistance program shall be comprised of but not limited to the following elements: resident assessment, emergency procedures, supervised practice in the safe operation of motor vehicles, familiarity with state regulations governing the transportation of persons with disabilities, maintenance and safety record keeping, training on hazardous driving conditions and a method for determining and documenting successful completion of the course. The course requirements above are examples and may be modified as needed.

(c) A valid New Mexico driver’s license for the type of vehicle being operated consistent with State of New Mexico requirements.

(3) Each regulated facility and agency shall establish and enforce written policies (including training) and procedures for employees who provide assistance to clients with boarding or alighting from motor vehicles.

(4) Each regulated facility and agency shall establish and enforce written policies (including training and procedures for employees who operate motor vehicles to transport clients.

CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must ensure that their personnel support staff have completed training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff.
agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
### Tag # 1A20 Direct Support Personnel Training

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

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

B. Staff shall complete individual-specific (formerly known as “Addendum B”) training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.

D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements.

E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.

F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.

G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not ensure Orientation and Training requirements were met for 8 of 77 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed as required:</td>
</tr>
</tbody>
</table>

**Assisting with Medication Delivery**
- Not Found (#511, 555, 573, 577)

**First Aid**
- Not Found (#538, 573, 576, 577)
- Expired (#522, 526)

**CPR**
- Not Found (#538, 573, 576, 577)
- Expired (#522, 526)

| Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): |
| Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): |

---

QMB Report of Findings – Nezzy Care of Las Cruces (Mayfield-Colt Corporation) – Southwest & Southeast Region – May 05 - 11, 2017

Survey Report #: Q.17.4/DDW.52981878.3/4.RTN.01.17.255
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.


**CHAPTER 5 (CIES) 3. Agency Requirements**

G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.

**CHAPTER 6 (CCS) 3. Agency Requirements**

F. Meet all training requirements as follows:
1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;

**CHAPTER 7 (CIHS) 3. Agency Requirements**

C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider
Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy

CHAPTER 11 (FL) 3. Agency Requirements
B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

CHAPTER 12 (SL) 3. Agency Requirements
B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training.
training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.

**CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.**

E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy:

<table>
<thead>
<tr>
<th>Week</th>
<th>Number</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A22 Agency Personnel Competency</td>
<td>Condition of Participation Level Deficiency</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>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) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 7 of 26 Direct Support Personnel. When DSP were asked if they received training on the Individual's Individual Service Plan and what the plan covered, the following was reported: • DSP #544 stated, “Do not track outcomes anymore.” (Individual #19) When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported: • DSP #555 stated, “No, sir.” According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #15) When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported: • DSP #522 stated, “No.” According to the Individual Specific Training Section of the ISP, the individual requires a Behavioral Crisis Intervention Plan. (Individual #16) When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:
A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.
B. Individual specific training must be arranged and conducted, including training on the

- DSP #539 stated, “No.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #14)
- DSP #555 stated, “I don't see a speech therapy plan.” According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #15)

When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:

- DSP #523 stated, “No.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #15)
- DSP #555 stated, “He does not.” According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #15)

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

- DSP #503 stated, “Not too sure.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Aspiration. (Individual #10)
- DSP #522 stated, “Seizures and falls.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for status of care Oral/Hygiene. (Individual #8)
Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

| QMB Report of Findings – Nezzy Care of Las Cruces (Mayfield-Colt Corporation) – Southwest & Southeast Region – May 05 - 11, 2017 |
| Survey Report #: Q.17.4.DDW.52981878.3/4.RTN.01.17.255 |

<table>
<thead>
<tr>
<th>Individual specific training must be arranged and conducted, including training on the ISP</th>
</tr>
</thead>
</table>

| DSP #523 stated, “No, he doesn't.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Support for Hydration, Aspiration Risk, Seizures, Paralysis present, Signs and Symptoms of Reflux, Constipation, Bowel and Bladder, Spasticity, and Skin and Wound. (Individual #15) |

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

| DSP #503 stated, “Not too sure, would call 911.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Aspiration. (Individual #10) |

| DSP #525 stated, “No, he doesn't have a MERP.” As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Aspiration. (Individual #9) |

| DSP #555 stated, “Blood Glucose monitoring and Diabetes.” As indicated by the Individual Specific Training section of the ISP indicates the Individual also requires Medical Emergency Response Plans for: Falls, Anxiety and Hypertension. (Individual #2) |

When DSP were asked what the individual’s Diagnosis were, the following was reported:

<p>| DSP #555 stated, “Diabetes, Cerebral Palsy, Anxiety, Depression, Paraplegia, Obsessive compulsive, Mild MR, and Spasticity.” According to the individuals e-CHAT the individual is also diagnosed with |</p>
<table>
<thead>
<tr>
<th>Outcomes, actions steps and strategies, associated support plans (e.g. healthcare plans, MERP, PBSP and BCIP, etc), and information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.</th>
<th>Hyperlipidemia and Hypertension. Staff did not discuss the listed diagnosis. (Individual #2)</th>
</tr>
</thead>
</table>

**CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.**

E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
| Tag # 1A25 | Caregiver Criminal History Screening | Condition of Participation Level Deficiency | Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): → |

**NMAC 7.1.9.8  CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS:**

**F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider.

**NMAC 7.1.9.9  CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:**

**A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section.

1) In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department’s notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime.

2) An applicant’s, caregiver’s or hospital caregiver’s failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a disqualifying conviction shall result in the disqualification of that applicant, caregiver, or hospital caregiver from the Employment Program.

*After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.*

Based on record review, the Agency did not maintain documentation indicating no “disqualifying convictions” or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 4 of 99 Agency Personnel.

The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:

- **Direct Support Personnel (DSP):**
  - #551 – Date of hire 10/1/2011.
  - #555 – Date of hire 10/24/2016.

The following Agency Personnel Files contained evidence of Caregiver Criminal History Screenings, which were not specific to the current term of employment:

- **Direct Support Personnel (DSP):**

The following Agency Personnel Files contained a letter of disqualification from the Caregiver Criminal History Screening Program:

- **Direct Support Personnel (DSP):**
disqualifying conviction shall result in the applicant’s, caregiver’s or hospital caregiver’s temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9.

(3) The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9.

B. Employment Pending Reconsideration Determination: At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration.

- #577 – Date of hire 10/6/2016.
(Note: Letter from CCHSP on 11/8/2016 stated “Determination of Temporary Disqualification for Non-Compliance requires the above referenced applicant/caregiver to be immediately terminated.” Employee terminated 5/10/2017 and rehired 5/10/2017.)
NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS. The following felony convictions disqualify an applicant, caregiver or hospital caregiver from employment or contractual services with a care provider:

A. homicide;

B. trafficking, or trafficking in controlled substances;

C. kidnapping, false imprisonment, aggravated assault or aggravated battery;

D. rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses;

E. crimes involving adult abuse, neglect or financial exploitation;

F. crimes involving child abuse or neglect;

G. crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or

H. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.
<table>
<thead>
<tr>
<th>Tag # 1A26  Consolidated On-line Registry/Employee Abuse Registry</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry.</td>
<td>Based on record review, the Agency did not maintain documentation in the employee’s personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 11 of 99 Agency Personnel. The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:</td>
<td></td>
</tr>
<tr>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Provider requirement to inquire of registry. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry.</td>
<td>Service Coordination Personnel (SC):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #515 - Date of hire 9/22/2009.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct Support Personnel (DSP):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #510 - Date of hire 7/8/2016, completed 7/13/2016.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #542 - Date of hire 1/30/2017, completed 1/31/2017.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #550 - Date of hire 7/8/2016, completed 7/29/2016.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #565 - Date of hire 9/22/2016, completed 12/20/2016.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #566 - Date of hire 7/11/2016, completed 7/29/2016.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• #569 - Date of hire 7/8/2016, completed 7/19/2016.</td>
<td></td>
</tr>
</tbody>
</table>
an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation.

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

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

- #576 - Date of hire 9/22/2016, completed 2/08/2017.
- #577 - Date of hire 10/6/2016, completed 10/17/2016.
- #578 - Date of hire 9/6/2016, completed 12/20/2016.
- #579 - Date of hire 10/28/2016, completed 11/02/2016.
<table>
<thead>
<tr>
<th>Tag # 1A28.1 Incident Mgt. System - Personnel Training</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</strong></td>
<td>Based on record review and interview, the Agency did not ensure Incident Management Training for 19 of 81 Agency Personnel.</td>
<td></td>
</tr>
<tr>
<td><strong>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</strong></td>
<td><strong>Direct Support Personnel (DSP)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A. General:</strong> All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner.</td>
<td>- Incident Management Training (Abuse, Neglect and Exploitation) (#501, 506, 509, 525, 532, 533, 542, 543, 551, 553, 554, 561, 563, 573, 577, 589, 604)</td>
<td></td>
</tr>
<tr>
<td><strong>B. Training curriculum:</strong> Prior to an employee or volunteer’s initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider’s facility. Training shall be conducted in a language that is understood by the employee or volunteer.</td>
<td><strong>When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect or Exploitation, the following was reported:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- DSP #503 stated, “APS.” Staff was not able to identify the State Agency as Division of Health Improvement.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- DSP #555 stated, “I don’t know.” Staff was not able to identify the State Agency as Division of Health Improvement.</td>
<td></td>
</tr>
</tbody>
</table>

| Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → |
C. Incident management system training curriculum requirements:

(1) The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:

(a) an overview of the potential risk of abuse, neglect, or exploitation;

(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;

(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;

(d) specific instructions on how to respond to abuse, neglect, or exploitation;

(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.

(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.

(3) All new employees and volunteers shall receive training prior to providing services to consumers.

D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer.
to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer’s training for a period of at least three years, or six months after termination of an employee's employment or the volunteer’s work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative’s request. Failure to provide employee and volunteer training documentation shall subject the 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 competent and qualified staff.

C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.
<table>
<thead>
<tr>
<th>Tag # 1A37 Individual Specific Training</th>
<th>Standard Level Deficiency</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>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) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</td>
<td>Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 2 of 81 Agency Personnel. Review of personnel records found no evidence of the following: <strong>Direct Support Personnel (DSP)</strong>  - Individual Specific Training (#573) <strong>Service Coordination Personnel (SC)</strong>  - Individual Specific Training (#515)</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
<tr>
<td>CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

QMB Report of Findings – Nezzy Care of Las Cruces (Mayfield-Colt Corporation) – Southwest & Southeast Region – May 05 - 11, 2017

Survey Report #: Q.17.4.DDW.52981878.3/4.RTN.01.17.255

Page 43 of 108
status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP’s or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and
Documentation for DDSD Training Requirements.

B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 12 (SL) 3. Agency Requirements
B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:

A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and
Documentation for DDSD Training Requirements.

B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual’s preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible.

CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Domain: Health and Welfare</strong> - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tag #</th>
<th>CQI System</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1A03</td>
<td>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</td>
<td>Based on record review, interview and observation, the Agency had not fully implemented their Continuous Quality Management System as required by standard.</td>
<td></td>
</tr>
<tr>
<td>d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. The entities or individuals responsible for conducting the discovery/monitoring processes;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. The types of information used to measure performance; and,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Review of the findings identified during the on-site survey (May 5 - 11, 2017) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
iv. The frequency with which performance is measured.


**Chapter 1 Introduction:**
As outlined in the quality assurance/quality improvement section in each of the service standards, all approved DDW providers are required to develop and utilize a quality assurance/quality improvement (QA/QI) plan to continually determine whether it operates in accordance with program requirements and regulations, achieves desired outcomes and identifies opportunities for improvement. CMS expects states to follow a continuous quality improvement process to monitor the implementation of the waiver assurances and methods to address identified problems in any area of non-compliance.

**CHAPTER 5 (CIES) 3. Agency Requirements: Quality Assurance Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the
methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. Implementing a QA/QI Committee:
The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:
i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

c. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

J. Significant program changes.

CHAPTER 6 (CCS) 3. Agency Requirements: Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing
within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements is working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement.
improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:
   i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
   ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

c. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

**Preparation of the Report:** The Provider Agency must complete a QA/QI report.
annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

CHAPTER 7 (CIHS) 3. Agency Requirements: Quality Assurance/Quality Improvement (QA/QI) Plan: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. Development of a QA/QI plan: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be
aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:**

The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:
   
   a. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
   
   b. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;
c. Patterns in reportable incidents;
f. Sufficiency of staff coverage;
g. Patterns in medication errors;
h. Action taken regarding individual grievances;
i. Presence and completeness of required documentation; and
j. Significant program changes.

3. **Preparation of the Report**: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

**CHAPTER 11 (FL) 3. Agency Requirements:**

**H. Quality Improvement/Quality Assurance (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan**: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI plan**: The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must
describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance;

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. Implementing a QA/QI Committee:
The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:

i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

c. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

J. Significant program changes.

**Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above

**CHAPTER 12 (SL) 3. Agency Requirements:**

**B. Quality Assurance/Quality Improvement (QA/QI) Program:**

**Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain
an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements is working. The plan shall include but is not limited to:

   a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

   b. The entities or individuals responsible for conducting the discovery/monitoring process;

   c. The types of information used to measure performance; and

   d. The frequency with which performance is measured.
2. **Implementing a QA/QI Committee:**
The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

   a. Implementation of the ISP, including:
      
      i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and

      ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

   b. Compliance with Caregivers Criminal History Screening requirements;

   c. Compliance with Employee Abuse Registry requirements;

   d. Compliance with DDSD training requirements;

   e. Patterns in reportable incidents;

   f. Sufficiency of staff coverage;

   g. Patterns in medication errors;

   h. Action taken regarding individual grievances;

   i. Presence and completeness of required documentation; and
j. Significant program changes.

**Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.

**CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Program:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to:

a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the
individual’s and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance.

b. The entities or individuals responsible for conducting the discovery/monitoring process;

c. The types of information used to measure performance; and

d. The frequency with which performance is measured.

2. **Implementing a QA/QI Committee:**
The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

a. Implementation of the ISP, including:
   i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
   
   ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;
d. Compliance with DDSD training requirements;

c. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

**Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.


**Program: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services.

1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process:
discovery, remediation and improvement. It describes the frequency, the source and
types of information gathered, as well as the
methods used to analyze and measure
performance. The QA/QI plan must describe
how the data collected will be used to
improve the delivery of services and methods
to evaluate whether implementation of
improvements are working. The plan shall
include but is not limited to:

a. Activities or processes related to
discovery, i.e., monitoring and recording
the findings. Descriptions of
monitoring/oversight activities that occur
at the individual’s and provider level of
service delivery. These monitoring
activities provide a foundation for QA/QI
plan by generating information that can be
aggregated and analyzed to measure
the overall system performance.

b. The entities or individuals responsible for
conducting the discovery/monitoring
process;

c. The types of information used to measure
performance; and

d. The frequency with which performance is
measured.

2. Implementing a QA/QI Committee:
The QA/QI committee must convene on at
least a quarterly basis and as needed to
review monthly service reports, to identify
and remedy any deficiencies, trends, patterns,
or concerns as well as opportunities for quality
improvement. The QA/QI meeting must be
documented. The QA/QI review should
address at least the following:
a. Implementation of the ISP, including:
   i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and
   ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.

b. Compliance with Caregivers Criminal History Screening requirements;

c. Compliance with Employee Abuse Registry requirements;

d. Compliance with DDSD training requirements;

e. Patterns in reportable incidents;

f. Sufficiency of staff coverage;

g. Patterns in medication errors;

h. Action taken regarding individual grievances;

i. Presence and completeness of required documentation; and

j. Significant program changes.

3. **Preparation of the Report**: The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.
NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:  
F. Quality assurance/quality improvement program for community-based service providers:  
   F. Quality assurance/quality improvement program for community-based service providers:  
The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division’s investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program:  
(1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;  
(2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and  
(3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.
<table>
<thead>
<tr>
<th>Tag #</th>
<th>General Provider Requirements</th>
<th>Standard Level Deficiency</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A05</td>
<td>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT ARTICLE 14. STANDARDS FOR SERVICES AND LICENSING</td>
<td>Based on record review, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD policies and procedures.</td>
<td>State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
<tr>
<td></td>
<td>a. The PROVIDER agrees to provide services as set forth in the Scope of Service, in accordance with all applicable regulations and standards including the current DD Waiver Service Standards and MF Waiver Service Standards.</td>
<td>Review of Agency policies and procedures found the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ARTICLE 39. POLICIES AND REGULATIONS</td>
<td>The following policies and procedures showed no evidence of being reviewed every three years or being updated as needed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider Agreements and amendments reference and incorporate laws, regulations, policies, procedures, directives, and contract provisions not only of DOH, but of HSD…</td>
<td>• On-call system, including nursing on-call - Last reviewed 9/2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chapter 1 Introduction: The objective of these standards is to establish provider policy, procedure and reporting requirements for the DDW Medicaid Program. These requirements apply to all provider agencies and staff whether directly employed or subcontracting with the approved provider agency.</td>
<td>• Medication Errors - Last reviewed 9/2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Storage of medication – Last reviewed 9/2012.</td>
<td></td>
</tr>
</tbody>
</table>

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → |
<table>
<thead>
<tr>
<th>Tag # 1A09  Medication Delivery - Routine Medication Administration</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Medication Administration Records (MAR) were reviewed for the months of April and May 2017. Based on record review, 1 of 18 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #7 May 2017 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: 1. Nexium 40mg (1 time daily) – Blank 5/5 (8:00 AM) 2. Minocycline 100mg (2 times daily) – Blank 5/5 (8:00 AM)</td>
<td>Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
</tr>
<tr>
<td>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:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • 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. | | |


CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. C. Small Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. D. Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy.

CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services: The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):

19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy,
New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and

I. Healthcare Requirements for Family Living.

3. B. Adult Nursing Services for medication oversight are required for all surrogate Living Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.

6. Support Living- Family Living Provider Agencies must 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 New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.

a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

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

i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;
ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;

v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

c. The Family Living Provider Agency must 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; and

d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.

e. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication
changes to the provider agency in a timely manner to insure accuracy of the MAR.

i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments.

ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements.

iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided.

CHAPTER 12 (SL) 2. Service Requirements K. Training and Requirements: 3. Supported Living Provider Agencies must 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, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;
b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:

i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;

v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

c. When PRN medications are used, there must be clear documentation that the DSP contacted the agency nurse prior to assisting with the medication.

d. The Supported Living Provider Agency must 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; and
e. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs, and symptoms of adverse events and interactions with other medications.

CHAPTER 13 (IMLS) 2. Service Requirements. B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.


CHAPTER 1 II. PROVIDER AGENCY Requirements: 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.
(1) All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals shall be licensed by the Board of Pharmacy, per current regulations.
(2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include:
(a) The name of the individual, a transcription of the physician’s written or licensed
health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed;

(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration;

(c) Initials of the individual administering or assisting with the medication;

(d) Explanation of any medication irregularity;

(e) Documentation of any allergic reaction or adverse medication effect; and

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

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

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

(5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications;
<table>
<thead>
<tr>
<th>Tag # 1A09.1 Medication Delivery - PRN Medication Administration</th>
<th>Standard Level Deficiency</th>
<th>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Medication Administration Records (MAR) were reviewed for the months of April and May, 2017. Based on record review, 1 of 18 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #15 May 2017 Physician’s Orders indicated the following medication was to be given. The following Medication was not documented on the Medication Administration Records: • Ibuprofen 400mg (PRN)</td>
<td>→</td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• the exact amount to be used in a 24-hour period.


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.).


CHAPTER 11 (FL) 1 SCOPE OF SERVICES
A. Living Supports- Family Living Services:
The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT):
19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD’s Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and
I. Healthcare Requirements for Family Living.
3. B. Adult Nursing Services for medication oversight are required for all surrogate Living Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication.
6. Support Living- Family Living Provider Agencies must 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 New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.

f. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

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

   i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;
   ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;
   iii. Initials of the individual administering or assisting with the medication delivery;
   iv. Explanation of any medication error;
   v. Documentation of any allergic reaction or adverse medication effect; and
   vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

h. The Family Living Provider Agency must 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; and
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications.</td>
<td></td>
</tr>
<tr>
<td>j. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR.</td>
<td></td>
</tr>
<tr>
<td>iv. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual’s response to medications for purpose of accurately completing required nursing assessments.</td>
<td></td>
</tr>
</tbody>
</table>
v. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements. |   |
|vi. If the substitute care provider is a surrogate (not related by affinity or consanguinity) |   |
Medication Oversight must be selected and provided.

**CHAPTER 12 (SL) 2. Service Requirements**

**K. Training and Requirements: 3.** Supported Living Provider Agencies must 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, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.

a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;

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

i. The name of the individual, a transcription of the physician’s or licensed health care provider’s prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed;

ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;

iii. Initials of the individual administering or assisting with the medication delivery;

iv. Explanation of any medication error;
v. Documentation of any allergic reaction or adverse medication effect; and

vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.

n. The Supported Living Provider Agency must 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; and

o. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs, and symptoms of adverse events and interactions with other medications.

CHAPTER 13 (IMLS) 2. Service Requirements. B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.


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

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

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

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

| standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. |
|---|---|
| E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. |
| (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: |
| (a) The name of the individual, a transcription of the physician’s written or licensed health care provider’s prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; |
| (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; |
| (c) Initials of the individual administering or assisting with the medication; |
| (d) Explanation of any medication irregularity; |
| (e) Documentation of any allergic reaction or adverse medication effect; and |
(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;
<table>
<thead>
<tr>
<th>Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training</th>
<th>Standard Level Deficiency</th>
<th></th>
</tr>
</thead>
</table>
| **7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** | Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 4 of 18 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: Incident Mgt. System - Parent/Guardian Training  
- Not Found (#3, 10, 16, 17) | Provider: State your Plan of Correction for the deficiencies cited in this tag here *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →  |
| **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. |  |  |
| **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer’s file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation. |  | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →  |
Tag # 1A31  Client Rights/Human Rights

**Condition of Participation Level Deficiency**

<table>
<thead>
<tr>
<th>Condition of Participation Level 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>
</tr>
<tr>
<td>Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 18 Individuals.</td>
</tr>
<tr>
<td>A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions.</td>
</tr>
<tr>
<td>No documentation was found regarding Human Rights Approval for the following:</td>
</tr>
<tr>
<td>- Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #4)</td>
</tr>
<tr>
<td>- Physical Restraint - No evidence found of Human Rights Committee approval. (Individual #4)</td>
</tr>
<tr>
<td>- Physical Restraint - No evidence found of Human Rights Committee approval. (Individual #8)</td>
</tr>
</tbody>
</table>

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?):

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?):

---

**Long Term Services Division**

**Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003**

---

QMB Report of Findings – Nezzy Care of Las Cruces (Mayfield-Colt Corporation) – Southwest & Southeast Region – May 05 - 11, 2017

Survey Report #: Q.17.4.DDW.52981878.3/4.RTN.01.17.255
IV. POLICY STATEMENT - Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans.

Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies:

- Aversive Intervention Prohibitions
- Psychotropic Medications Use
- Behavioral Support Service Provision.

A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up.

A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS

Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval.

2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly.

3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years.
years from the completion of each individual’s Individual Service Plan.

**Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:**

**Medication Assessment and Delivery**

**Procedure Eff Date:** November 1, 2006

**B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency’s Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).
<table>
<thead>
<tr>
<th>Tag # 1A33</th>
<th>Board of Pharmacy - Med Storage</th>
</tr>
</thead>
</table>

**New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual**

**E. Medication Storage:**

1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee.
2. Drugs to be taken by mouth will be separate from all other dosage forms.
3. A locked compartment will be available in the refrigerator for those items labeled “Keep in Refrigerator.” The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature.
4. Separate compartments are required for each resident’s medication.
5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day.
6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist.

**8. References:** A. Adequate drug references shall be available for facility staff

**H. Controlled Substances (Perpetual Count Requirement)**

1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance, indicating the following information:
   a. date
   b. time administered
   c. name of patient
   d. dose

---

Based on record review and observation, the Agency did not ensure proper storage of medication for 2 of 18 individuals.

**Observation included:**

**Board of Pharmacy - Med Storage**

**Individual #3**
- Aspirin: expired 4/10/2017. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.

**Individual #7**
- One-a-day: expired 10/2013. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.

---

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →

---

**Provider:**

Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →
<table>
<thead>
<tr>
<th>e. practitioner’s name</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>f. signature of person administering or assisting with the administration the dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. balance of controlled substance remaining</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tag # 1A33.1 Board of Pharmacy – License</td>
<td>Standard Level Deficiency</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------</td>
<td>---</td>
</tr>
<tr>
<td>New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual 6. Display of License and Inspection Reports A. The following are required to be publicly displayed:</td>
<td>Based on observation, the Agency did not provide the current Custodial Drug Permit from the New Mexico Board of Pharmacy, the current registration from the Consultant Pharmacist, or the current New Mexico Board of Pharmacy Inspection Report for 3 of 11 residential and/or service sites where required:</td>
<td>Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →</td>
</tr>
</tbody>
</table>
|   • Current Custodial Drug Permit from the NM Board of Pharmacy  
   • Current registration from the consultant pharmacist  
   • Current NM Board of Pharmacy Inspection Report | **Individual Residence:**  
   • Current Custodial Drug Permit from the NM Board of Pharmacy (#7, 8, 15, 16)  
*Note: The following Individuals share a residence:*
  ➢ #7, 15 | Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → |
| | | |

QMB Report of Findings – Nezzy Care of Las Cruces (Mayfield-Colt Corporation) – Southwest & Southeast Region – May 05 - 11, 2017

Survey Report #: Q.17.4.DDW.52981878.3/4.RTN.01.17.255
<table>
<thead>
<tr>
<th>Tag #</th>
<th>Residential Health and Safety (SL/FL)</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>LS25 / 6L25</td>
<td>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015</td>
<td>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</td>
<td>How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?: →</td>
</tr>
<tr>
<td></td>
<td>CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports - Family Living Services: 1. Family Living Services providers must assure that each individual’s residence is maintained to be clean, safe and comfortable and accommodates the individuals’ daily living, social and leisure activities. In addition, the residence must:</td>
<td>Based on observation, the Agency did not ensure that each individuals’ residence met all requirements within the standard for 10 of 11 Supported Living and Family Living residences.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></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>
</tr>
<tr>
<td></td>
<td>a. Maintain basic utilities, i.e., gas, power, water and telephone;</td>
<td>Supported Living Requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;</td>
<td>Water temperature in home does not exceed safe temperature (110°F)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;</td>
<td>- Water temperature in home measured 128.9°F (#7, 15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Have a general-purpose first aid kit;</td>
<td>- Water temperature in home measured 120.4°F (#16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;</td>
<td>- General-purpose first aid kit (#7, 15)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#2, 3, 7, 8, 15, 16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></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 (#2, 3, 7, 8, 15, 16)</td>
<td></td>
</tr>
</tbody>
</table>
f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year;

g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual’s ISP; and

h. Have 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 must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports - Supported Living Services: 1. Supported Living Provider Agencies must assure that each individual’s residence is maintained to be clean, safe, and comfortable and accommodates the individual’s daily living, social, and leisure activities. In addition, the residence must:

a. Maintain basic utilities, i.e., gas, power, water, and telephone;

b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;

- 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 (#2, 3, 7, 8, 15, 16)

Note: The following Individuals share a residence:
- #7, 15

Family Living Requirements

- Fire Extinguisher (#14)
- Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#14, 19)
- Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#5, 10, 14, 18, 19)
- 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 (#5, 10, 14, 18, 19)
- 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 (#5, 10, 14, 18, 19)
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Ensure water temperature in home does not exceed safe temperature ($110^\circ F$);</td>
<td></td>
</tr>
<tr>
<td>d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;</td>
<td></td>
</tr>
<tr>
<td>e. Have a general-purpose First Aid kit;</td>
<td></td>
</tr>
<tr>
<td>f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;</td>
<td></td>
</tr>
<tr>
<td>g. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift;</td>
<td></td>
</tr>
<tr>
<td>h. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and</td>
<td></td>
</tr>
<tr>
<td>i. Have 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 must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.</td>
<td></td>
</tr>
</tbody>
</table>

**CHAPTER 13 (IMLS) 2. Service Requirements**

**R. Staff Qualifications:**

**3. Supervisor Qualifications And Requirements:**
S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies.

T Each residence shall have a blood borne pathogens kit as applicable to the residents’ health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home.

U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions.

V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees.
<table>
<thead>
<tr>
<th>Standard of Care</th>
<th>Deficiencies</th>
<th>Agency Plan of Correction, On-going QA/QI &amp; Responsible Party</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Domain: Medicaid Billing/Reimbursement</strong> - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tag # IS25 / SI25  Community Integrated Employment Services / Supported Employment Reimbursement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHAPTER 5 (CIES) 4. REIMBURSEMENT:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Community Integrated Employment Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Community Integrated Employment Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Billable Units:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The billable unit for Community Integrated Employment, which includes Job Development and Job Maintenance, is a monthly unit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The billable unit for Group Community Integrated Employment is a fifteen (15) minute unit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The billable unit for Intensive Community Integrated Employment is an hourly unit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 5 individuals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual #18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>January 2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The Agency billed 1 unit of Community Integrated Employment (T2025 HB UA) from 1/1/2017 through 1/31/2017. No Documentation was found for 1/1/2017 through 1/31/2017 to justify the 1 unit billed. (Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider:</strong> Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. Billable Activities:

1. Self and Individual Community Integrated Employment, Community Inclusion Aide: All one-to-one (1:1) DSP activities that are included in the individual's approved ISP and delivered in accordance with the Scope of Services, and not included in non-billable services, activities or situations.

2. Self-Employment may include non-face-to-face activity in support of the participant’s business up to 50% of the billable time. The activities include development of a business plan and market analysis, marketing, advertising, DVR referral, document submission and processing regarding taxes or licenses, processing or filling orders.

3. Group Community Integrated Employment: All DSP face to face activities with the consumer as specified in the Scope of Services, the individual's approved ISP and the performance based contract, and which are not included in non-billable services, activities or situations.

4. Job Development: both face to face and non-face to face activities as described in the Scope of Services, the individual's approved ISP and the performance based contract. 50% of billable activities must be face to face.

5. Conducting the Vocational Assessment Profile (VAP) or other vocational assessment.

6. A minimum of four (4) hours of service must be provided monthly with a maximum of forty (40) hours per month for Community Integrated Employment Job Maintenance. The rate structure assumes a caseload of five (5)
individuals per job developer which allows for an average support of approximately 22 hours of support per individual per month.

**NMAC 8.302.1.17 Effective Date 9-15-08**

**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.

**Detail Required in Records** - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

**Services Billed by Units of Time** - Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

**Records Retention** - A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

1. treatment or care of any eligible recipient
2. services or goods provided to any eligible recipient
3. amounts paid by MAD on behalf of any eligible recipient; and
4. any records required by MAD for the administration of Medicaid.
| Tag # IS30  Customized Community Supports Reimbursement | Standard Level Deficiency | Provider: State your Plan of Correction for the deficiencies cited in this tag here (How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →

Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here (What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): → |

| Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 3 of 12 individuals. |

**Individual #7**
February 2017
- The Agency billed 200 units of Customized Community Supports (Individual) (H2021 HB U1) from 1/30/2017 through 2/8/2017.
- Documentation received accounted for 144 units.

**Individual #8**
January 2017
- The Agency billed 380 units of Customized Community Supports (Group) (T2021 HB U9) from 1/2/2017 through 1/31/2017.
- Documentation received accounted for 356 units. *(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*

**Individual #10**
March 2017
- Documentation received accounted for 225 units. *(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* |

---

**CHAPTER 6 (CCS) 4. REIMBURSEMENT**

**A. Required Records:** Customized Community Supports Services Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. Customized Community Supports Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations.

**B. Billable Unit:**

1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit.

2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.

3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group assignment.

4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Base on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 3 of 12 individuals.

**Individual #7**
February 2017
- The Agency billed 200 units of Customized Community Supports (Individual) (H2021 HB U1) from 1/30/2017 through 2/8/2017.
- Documentation received accounted for 144 units.

**Individual #8**
January 2017
- The Agency billed 380 units of Customized Community Supports (Group) (T2021 HB U9) from 1/2/2017 through 1/31/2017.
- Documentation received accounted for 356 units. *(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*

**Individual #10**
March 2017
- Documentation received accounted for 225 units. *(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)*
Customized Community Supports without prior approval from DDSD.

5. The billable unit for Individual Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit.

6. The billable unit for Fiscal Management for Adult Education is one dollar per unit including a 10% administrative processing fee.

7. The billable units for Adult Nursing Services are addressed in the Adult Nursing Services Chapter.

C. **Billable Activities:**

All DSP activities that are:

a. Provided face to face with the individual;

b. Described in the individual's approved ISP;

c. Provided in accordance with the Scope of Services; and

d. Activities included in billable services, activities or situations.

Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes, not to exceed $550 including administrative processing fee.
Therapy Services, Behavioral Support Consultation (BSC), and Case Management may be provided and billed for the same hours, on the same dates of service as Customized Community Supports

NMAC 8.302.1.17 Effective Date 9-15-08
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.

Detail Required in Records - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

Services Billed by Units of Time - Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

Records Retention - A provider who receives payment for treatment, services or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:
(1) treatment or care of any eligible recipient
(2) services or goods provided to any eligible recipient
(3) amounts paid by MAD on behalf of any eligible recipient; and
(4) any records required by MAD for the administration of Medicaid.
Tag # LS27 / 6L27  Family Living Reimbursement

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAPTER 11 (FL) 5. REIMBURSEMENT</td>
</tr>
</tbody>
</table>

**A. Family Living Services Provider Agencies**

must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Family Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. Providers are required to comply with the New Mexico Human Services Department Billing Regulations

1. From the payments received for Family Living services, the Family Living Agency must:

   a. Provide a minimum payment to the contracted primary caregiver of $2,051 per month; and

   b. Provide or arrange up to seven hundred fifty (750) hours of substitute care as sick leave or relief for the primary caregiver.

Under no circumstances can the Family Living Provider agency limit how these hours will be used over the course of the ISP year. It is not allowed to limit the number of substitute care hours used in a given time period, other than an ISP year.

**B. Billable Units:**

<table>
<thead>
<tr>
<th>Standard Level Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Family Living Services for 2 of 7 Individuals.</td>
</tr>
</tbody>
</table>

| Individual #5 |
| January 2017 |
| The Agency billed 29 units of Family Living (T2033 HB) from 1/1/2017 through 1/29/2017. No documentation was found on 1/17 – 18, 2017. Documentation received accounted for 27 units. *(Note: Void/adjust provided during on-site survey. Provider please complete POC for ongoing QA/QI.)* |

| Individual #10 |
| January 2017 |
| The Agency billed 29 units of Family Living (T2033 HB) from 1/1/2017 through 1/29/2017. No documentation was found on 1/23 – 24, 2017 and on 1/25/2017 documentation received accounted for 0.5 units. Documentation received accounted for 26.5 units. |

**Provider:**

State your Plan of Correction for the deficiencies cited in this tag here *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?): →

Provider:
Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?): →
1. The billable unit for Family Living is based on a daily rate. A day is considered 24 hours from midnight to midnight. If 12 or less hours of service, are provided then one half unit shall be billed. A whole unit can be billed if more than 12 hours of service is provided during a 24 hour period.

2. The maximum allowable billable units cannot exceed three hundred forty (340) days per ISP year or one hundred seventy (170) days per six (6) months.

NMAC 8.302.1.17 Effective Date 9-15-08
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.

Detail Required in Records - Provider Records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services, length of a session of service billed, diagnosis and medical necessity of any service . . . Treatment plans or other plans of care must be sufficiently detailed to substantiate the level of need, supervision, and direction and service(s) needed by the eligible recipient.

Services Billed by Units of Time - Services billed on the basis of time units spent with an eligible recipient must be sufficiently detailed to document the actual time spent with the eligible recipient and the services provided during that time unit.

Records Retention - A provider who receives payment for treatment, services or goods must
retain all medical and business records relating to any of the following for a period of at least six years from the payment date:
(1) treatment or care of any eligible recipient
(2) services or goods provided to any eligible recipient
(3) amounts paid by MAD on behalf of any eligible recipient; and
(4) any records required by MAD for the administration of Medicaid.


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

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 the 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 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.

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

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 caregiving responsibilities while maintaining adequate supervision and support to the individual during the absence of the primary caregiver.
Date: December 12, 2017

To: Ramon V. Chavez, Executive Director
Provider: Nezzy Care of Las Cruces (Mayfield-Colt Corporation)
Address: 780 S Walnut Street, Bldg. 7
State/Zip: Las Cruces, New Mexico 88001

E-mail Address: nezzclc@hotmail.com

Region: Southwest and Southeast
Survey Date: May 05 - 11, 2017

Program Surveyed: Developmental Disabilities Waiver
Service Surveyed: 2007: Supported Living and Adult Habilitation

Survey Type: Routine

Dear Ramon V. Chavez;

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 the health, safety and personal growth of the people you serve.
Sincerely,

Amanda Castañeda

Amanda Castañeda  
Plan of Correction Coordinator  
Quality Management Bureau/DHI

Q.17.4.DDW.52981878.3/4.RTN.09.17.346