

Date: July 26, 2019

To: Kimber Crowe, Executive Director  
Provider: Tohatchi Area of Opportunity & Services, Inc.  
Address: 1658 S. 2nd Street  
City, State, Zip: Gallup, New Mexico 87301

E-mail Address: [kimber.crowe@taos-inc.org](mailto:kimber.crowe@taos-inc.org)

Region: Northwest  
Routine Survey: December 3 - 6, 2018  
Verification Survey: June 28 – July 3, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012 & 2018:** Supported Living, Customized Community Supports, Community Integrated Employment Services

Survey Type: Verification

Team Leader: Monica Valdez, BS, Healthcare Surveyor Advanced / Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau

Team Member: Kayla Benally, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Kimber Crowe;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on December 3 – 6, 2019*.

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

**Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags:** This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags (*refer to Attachment D for details*). The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A31 Client Rights/Human Rights

The following tags are identified as Standard Level:

- Tag # 1A32.1 Administrative Case File: Individual Service Plan (Not Completed at Frequency)
- Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements
- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)

**DIVISION OF HEALTH IMPROVEMENT**

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108  
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QMB Report of Findings – Tohatchi Area of Opportunity & Services, Inc. – Northwest – June 28 – July 3, 2019

Survey Report #: Q.19.4.DDW.D1703.1.VER.01.19.207

- Tag # 1A43.1 General Events Reporting – Individual Reporting
- Tag # 1A29 Complaints / Grievances
- Tag # LS25 Residential Health and Safety (Supported Living)

However, due to the new/repeat deficiencies your agency will be referred to the Internal Review Committee (IRC). Your agency will also be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

**Plan of Correction:**

The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency’s verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance;
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report;
3. Documentation verifying that newly cited deficiencies have been corrected.

**Submission of your Plan of Correction:**

Please submit your agency’s Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

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

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

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

Please call the Plan of Correction Coordinator Monica Valdez at 505-273-1930 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,

*Monica Valdez, BS*

Monica Valdez, BS  
 Team Lead/Healthcare Surveyor Advanced/Plan of Correction Coordinator  
 Division of Health Improvement  
 Quality Management Bureau

## Survey Process Employed:

Administrative Review Start Date:	June 28, 2019
Contact:	<b><u>Tohatchi Area of Opportunity &amp; Services, Inc.</u></b> Kimber Crowe, Chief Executive Director  <b><u>DOH/DHI/QMB</u></b> Monica Valdez, BS, Team Lead/Healthcare Surveyor Advanced/Plan of Correction Coordinator
On-site Entrance Conference Date:	July 1, 2019
Present:	<b><u>Tohatchi Area of Opportunity &amp; Services, Inc.</u></b> Kimber Crowe, Chief Executive Officer Melinda Golden, Quality Assurance Manager Gerald Morris, Program Services Manager  <b><u>DOH/DHI/QMB</u></b> Monica Valdez, BS, Team Lead/Healthcare Surveyor Advanced/Plan of Correction Coordinator Kayla Benally, BSW, Healthcare Surveyor
Exit Conference Date:	July 2, 2019
Present:	<b><u>Tohatchi Area of Opportunity &amp; Services, Inc.</u></b> Kimber Crowe, Chief Executive Officer Melinda Golden, Quality Assurance Manager Gerald Morris, Program Services Manager  <b><u>DOH/DHI/QMB</u></b> Monica Valdez, BS, Team Lead/Healthcare Surveyor Advanced/Plan of Correction Coordinator Kayla Benally, BSW, Healthcare Surveyor
Administrative Locations Visited	1
Total Sample Size	6  0 - <i>Jackson</i> Class Members 6 - <i>Non-Jackson</i> Class Members  5 - Supported Living 6 - Customized Community Supports 3 - Community Integrated Employment Services
Persons Served Records Reviewed	6
Direct Support Personnel Interviewed during Routine Survey	5
Direct Support Personnel Records Reviewed	42
Service Coordinator Records Reviewed	1
Administrative Interviews completed during Routine Survey	1

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  
HSD - Medical Assistance Division  
NM Attorney General's Office

## 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 other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); 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 Assurance 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 during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. 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.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

#### Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

#### ***Service Domains and CoPs for Living Care Arrangements and Community Inclusion are as follows:***

***Service Domain: Service Plan: ISP Implementation - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.***

##### **Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A08.3** – Administrative Case File: Individual Service Plan / ISP Components
- **1A32** – Administrative Case File: Individual Service Plan Implementation
- **LS14** – Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14** – CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

***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.***

##### **Potential Condition of Participation Level Tags, if compliance is below 85%:**

- **1A20** - Direct Support Personnel Training

- 1A22 - Agency Personnel Competency
- 1A37 – Individual Specific Training

**Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):**

- 1A25.1 – Caregiver Criminal History Screening
- 1A26.1 – Consolidated On-line Registry Employee Abuse Registry

**Service Domain: Health, Welfare and Safety** - *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.*

**Potential Condition of Participation Level Tags, if compliance is below 85%:**

- 1A08.2 – Administrative Case File: Healthcare Requirements & Follow-up
- 1A09 – Medication Delivery Routine Medication Administration
- 1A09.1 – Medication Delivery PRN Medication Administration
- 1A15.2 – Administrative Case File: Healthcare Documentation (Therap and Required Plans)

**Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):**

- 1A05 – General Requirements / Agency Policy and Procedure Requirements
- 1A07 – Social Security Income (SSI) Payments
- 1A09.2 – Medication Delivery Nurse Approval for PRN Medication
- 1A15 – Healthcare Documentation - Nurse Availability
- 1A31 – Client Rights/Human Rights
- LS25.1 – Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

## 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: <https://nmhealth.org/about/dhi/cbp/irf/>
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](mailto: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.

## QMB Determinations of Compliance

### **Compliance:**

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or that no deficiencies at the Condition of Participation Level were found. 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*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

### **Partial-Compliance with Standard Level Tags:**

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.
2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

### **Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:**

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. 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.

### **Non-Compliance:**

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. 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. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.
2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
CoP Level Tags:	0 CoP	0 CoP	0 CoP	0 CoP	1 to 5 CoPs	0 to 5 CoPs	6 or more CoPs
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
<b>"Non-Compliance"</b>						17 or more Standard Level Tags with 75 to 100% of the Individuals in the sample cited in any tag.	Any Amount of Standard Level Tags and 6 or more Conditions of Participation Level Tags.
<b>"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"</b>					Any Amount of Standard Level Tags, plus 1 to 5 Conditions of Participation Level tags.		
<b>"Partial Compliance with Standard Level tags"</b>			up to 16 Standard Level Tags with 75 to 100% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 50 to 74% of the individuals in the sample cited any tag.			
<b>"Compliance"</b>	Up to 16 Standard Level Tags with 0 to 74% of the individuals in the sample cited in any tag.	17 or more Standard Level Tags with 0 to 49% of the individuals in the sample cited in any tag.					

**Agency:** Tohatchi Area of Opportunity & Services, Inc. – Northwest Region  
**Program:** Developmental Disabilities Waiver  
**Service:** 2012 & 2018: Supported Living, Customized Community Supports, Community Integrated Employment Services  
**Survey Type:** Verification  
**Routine Survey:** December 3 - 6, 2018  
**Verification Survey:** June 28 – July 3, 2019

Standard of Care	Routine Survey Deficiencies December 3 – 6, 2018	Verification Survey New and Repeat Deficiencies June 28 – July 3, 2019
<i>Service Domain: Service Plans: ISP Implementation - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.</i>		
<b>Tag # 1A32 Administrative Case File: Individual Service Plan Implementation</b>	<b>Condition of Participation Level Deficiency</b>	<b>Condition of Participation Level Deficiency</b>
<p><b>NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP.</b> The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on administrative 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 6 of 6 individuals.</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #2</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: “Staff will assist with researching dogs” for 8/2018 - 10/2018. Action step is to be completed 2 times per month.</li> <li>• None found regarding: Live Outcome/Action Step: “With staff assistance steps to getting a dog” for 8/2018 - 10/2018. Action step is to be completed 2 times per month.</li> </ul>	<p><b>New / Repeat Findings:</b></p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on administrative 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 1 of 6 individuals.</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• None found regarding: Work Outcome/Action Step: “With staff assistance research job opportunities” for 5/2019. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Work Outcome/Action Step: “With staff assistance fill out job application” for</li> </ul>

<p>services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p><b>Chapter 6: Individual Service Plan (ISP)</b>  <b>6.8 ISP Implementation and Monitoring:</b> All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.</p>	<p>Individual #3</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: “With assistance...will research and take a safety class” for 9/2018. Action step is to be completed 1 time per month.</li> <li>• None found regarding: Live Outcome/Action Step: “With assistance...will create a safety checklist” for 9/2018. Action step is to be completed 1 time per month.</li> <li>• None found regarding: Live Outcome/Action Step: “Will follow safety checklist” for 9/2018. Action step is to be completed 1 time per month.</li> </ul> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: “Will independently take a shower” for 8/2018. Action step is to be completed 1 time per month.</li> </ul> <p>Individual #5</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: “With assistance will vacuum bedroom” for 8/2018 - 10/2018. Action step is to be completed 2 times per month.</li> </ul> <p>Individual #6</p> <ul style="list-style-type: none"> <li>• None found regarding: Live Outcome/Action Step: “With staff assistance will sort clothes” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Live Outcome/Action Step: “Will place garment in washer” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Live Outcome/Action Step: “Will move garment to dryer” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.</li> </ul>	<p>5/2019. Action step is to be completed 2 times per month.</p>
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**Chapter 20: Provider Documentation and Client Records**

**20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.
2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.
4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.
5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.

- None found regarding: Live Outcome/Action Step: “Staff assistance will fold her garments” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.

- None found regarding: Live Outcome/Action Step: “With staff assistance will place garments in drawers” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.

**Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**

Individual #1

- None found regarding: Work/learn Outcome/Action Step: “With assistance research jobs in the community” for 8/2018 - 10/2018. Action step is to be completed 2 times per month.

- None found regarding: Work/learn Outcome/Action Step: “With assistance will fill out job application” for 8/2018 - 10/2018. Action step is to be completed 1 time per month.

Individual #2

- None found regarding: Fun Outcome/Action Step: “With staff assistance reach out to family” for 8/2018 - 10/2018. Action step is to be completed 1 time per month.

- None found regarding: Fun Outcome/Action Step: “With assistance plan day with family” for 8/2018 - 10/2018. Action step is to be completed 1 time per month.

- None found regarding: Fun Outcome/Action Step: “Attend” for 8/2018 - 10/2018. Action step is to be completed 1 time per month.

6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.  
 7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

- None found regarding: Work/learn Outcome/Action Step: “With staff assistance volunteer at the Humane Society caring for dogs” for 8/2018 - 10/2018. Action step is to be completed 1 time per month.
  - None found regarding: Work/learn Outcome/Action Step: “With staff assistance care for dog” for 8/2018 - 10/2018. Action step is to be completed 1 time daily.
- Individual #3
- None found regarding: Fun Outcome/Action Step: “Will identify friends she wants to invite to an activity” for 8/2018 - 9/2018. Action step is to be completed 1 time per month.
  - None found regarding: Fun Outcome/Action Step: “With assistance...will plan and invite her new friend to an activity of her choice” for 8/2018 - 9/2018. Action step is to be completed 1 time per month.
- Individual #4
- None found regarding: Fun Outcome/Action Step: “Will research places” for 8/2018. Action step is to be completed 1 time per month.
  - None found regarding: Fun Outcome/Action Step: “Will choose and invite friend” for 8/2018. Action step is to be completed 1 time per month.
  - None found regarding: Fun Outcome/Action Step: “Will attend” for 8/2018. Action step is to be completed 1 time per month.
- Individual #5
- None found regarding: Fun Outcome/Action Step: “With assistance research spa locations” for

	<p>8/2018 – 9/2018. Action step is to be completed 1 time per month.</p> <ul style="list-style-type: none"> <li>• None found regarding: Fun Outcome/Action Step: “With assistance make an appointment for spa treatment” for 8/2018 – 9/2018. Action step is to be completed 1 time per month.</li> <li>• None found regarding: Fun Outcome/Action Step: “With assistance attend spa treatment” for 8/2018 – 9/2018. Action step is to be completed 1 time per month.</li> </ul> <p><b>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/learn Outcome/Action Step: “With assistance...will talk with supervisor about new job details” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Work/learn Outcome/Action Step: “With assistance...will participate in job duties” for 8/2018 - 9/2018. Action step is to be completed 1 time per week.</li> </ul> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• None found regarding: Work/learn Outcome/Action Step: “With staff assistance research job opportunities” for 8/2018. Action step is to be completed 1 time per week.</li> <li>• None found regarding: Work/learn Outcome/Action Step: “With staff assistance fill out job application” for 8/2018. Action step is to be completed 2 times per month.</li> </ul>	
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	<ul style="list-style-type: none"><li>• None found regarding: Work/learn Outcome/Action Step: "With staff create a budget" for 8/2018. Action step is to be completed 1 time per month.</li><li>• None found regarding: Work/learn Outcome/Action Step: "...with staff assistance take a picture of items he wants" for 8/2018. Action step is to be completed 2 times per month.</li><li>• None found regarding: Work/learn Outcome/Action Step: "Staff assistance compare money and picture" for 8/2018. Action step is to be completed 1 time per month.</li><li>• None found regarding: Work/learn Outcome/Action Step: "Purchase items" for 8/2018. Action step is to be completed 1 time per month.</li></ul>	
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Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation (Not Completed at Frequency)	Standard Level Deficiency	Standard Level Deficiency
<p><b>NMAC 7.26.5.16.C and D Development of the ISP.</b> Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disability's division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>D. The intent is to provide choice and obtain opportunities for individuals to live, work and</p>	<p>Based on administrative 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 1 of 6 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #4</p> <ul style="list-style-type: none"> <li>• According to the Live Outcome; Action Step for "...will independently take a shower" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2018.</li> </ul>	<p><b>New / Repeat Findings:</b></p> <p>Based on administrative 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 6 individuals.</p> <p>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p><b>Administrative Files Reviewed:</b></p> <p><b>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #1</p> <ul style="list-style-type: none"> <li>• According to the Fun Outcome; Action Step for "With staff assistance explore activities" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.</li> <li>• According to the Fun Outcome; Action Step for "...will choose activity and invite friend" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.</li> <li>• According to the Fun Outcome; Action Step for "Attend" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.</li> </ul>

play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019

**Chapter 6: Individual Service Plan (ISP)**

**6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies.

**Chapter 20: Provider Documentation and Client Records**

**20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the

Individual #2

- According to the Work/Learn Outcome; Action Step for “Care for a dog” is to be completed 1 time daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.
- According to the Fun Outcome; Action Step for “Choose a friend and activity” is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.
- According to the Fun Outcome; Action Step for “Attend” is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.

Individual #3

- According to the Fun Outcome; Action Step for “Will identify friends she wants to invite to an activity” is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.
- According to the Fun Outcome; Action Step for “With assistance...will plan and invite her new friends to an activity of her choice” is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 5/2019.

Individual #4

- According to the Work/Learn Outcome; Action Step for “Maintain” is to be completed 1 time per week. Evidence found indicated it was not being completed

<p>location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following:</p> <p>8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</p> <p>9. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices</p> <p>10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</p> <p>11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</p> <p>12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</p> <p>13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.</p> <p>14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.</p>		<p>at the required frequency as indicated in the ISP for 5/2019.</p> <p><b>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</b></p> <p>Individual #3</p> <ul style="list-style-type: none"> <li>• According to the Work/Learn Outcome; Action Step for “With assistance...will talk with supervisor about new job duties” 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 5/2019.</li> </ul>
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Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	Standard Level Deficiency	Standard Level Deficiency
<p><b>7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE:</b></p> <p>C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed.</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to</p>	<p>Based on record review, the Agency did not complete written status reports as required for 6 of 6 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p><b>Supported Living Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #3 - None found for 11/2017 - 4/2018 and 5/2018 – 8/2018. <i>(Term of ISP 11/9/2017 – 11/8/2018. ISP meeting held on 8/21/2018).</i></li> <li>Individual #4 - None found for 2/2018 - 8/2018 and 8/2018 – 10/2018. <i>(Term of ISP 2/28/2018 – 2/27/2019. ISP meeting held on 11/8/2017).</i></li> <li>Individual #5 - None found for 2/2018 - 8/2018. <i>(Term of ISP 2/8/2018 – 2/27/2019).</i></li> <li>Individual #6 - None found for 8/2017 - 2/2018 and 2/2018 – 4/2018. <i>(Term of ISP 8/11/2017 – 8/10/2018. ISP meeting held on 4/16/2018).</i></li> </ul> <p><b>Customized Community Supports Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #1 - None found for 7/2017 - 8/2017. <i>(Term of ISP 1/1/2017 – 12/31/2018. ISP meeting held on 9/13/2017).</i></li> <li>Individual #2 - None found for 8/2017 - 2/2018 and 2/2018 – 5/2018. <i>(Term of ISP 8/13/2017 – 8/12/2018. ISP meeting held on 5/17/2018).</i></li> <li>Individual #3 - None found for 11/2017 - 4/2018 and 5/2018 – 8/2018. <i>(Term of ISP 11/9/2017 – 11/8/2018. ISP meeting held on 8/21/2018).</i></li> </ul>	<p><b>New / Repeat Findings:</b></p> <p>Based on record review, the Agency did not complete written status reports as required for 5 of 6 individuals receiving Living Care Arrangements and Community Inclusion.</p> <p><b>Supported Living Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #3 - None found for 11/2018 - 4/2019. <i>(Term of ISP 11/9/2018 – 11/8/2019).</i></li> </ul> <p><b>Customized Community Supports Semi-Annual Reports:</b></p> <ul style="list-style-type: none"> <li>Individual #1 - None found for 7/2018. <i>(Term of ISP 1/1/2018 – 12/31/2018. ISP meeting held on 8/15/2018).</i></li> <li>Individual #2 - None found for 8/2018 - 2/2019. <i>(Term of ISP 8/13/2018 – 8/12/2019).</i></li> <li>Individual #3 - None found for 11/2018 - 4/2019. <i>(Term of ISP 11/9/2018 – 11/8/2019).</i></li> </ul>

adhere to the following:

1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.
2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.
3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.
4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.
5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.
6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.
7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

**Chapter 19: Provider Reporting  
Requirements: 19.5 Semi-Annual Reporting:**

- Individual #4 - None found for 2/2018 - 8/2018 and 8/2018 – 10/2018. *(Term of ISP 2/28/2018 – 2/27/2019. ISP meeting held on 11/8/2017).*

- Individual #5 - None found for 2/2018 - 8/2018. *(Term of ISP 2/8/2018 – 2/7/2019).*

**Community Integrated Employment Services  
Semi-Annual Reports:**

- Individual #3 - None found for 11/2017 - 4/2018 and 5/2018 – 8/2018. *(Term of ISP 11/9/2017 – 11/8/2018. ISP meeting held on 8/21/2018).*

- Individual #5 - None found for 2/2018 - 8/2018. *(Term of ISP 2/8/2018 – 2/7/2019).*

**Nursing Semi-Annual / Quarterly Reports:**

- Individual #2 - None found for 8/2017 - 2/2018 and 2/2018 – 5/2018. *(Term of ISP 8/13/2017 – 8/12/2018. ISP meeting held on 5/17/2018).*

- Individual #5 - None found for 2/2018 - 8/2018. *(Term of ISP 2/8/2018 – 2/7/2019).*

The semi-annual report provides status updates to life circumstances, health, and progress toward ISP goals and/or goals related to professional and clinical services provided through the DD Waiver. This report is submitted to the CM for review and may guide actions taken by the person's IDT if necessary. Semi-annual reports may be requested by DDSD for QA activities.

Semi-annual reports are required as follows:

1. DD Waiver Provider Agencies, except AT, EMSP, Supplemental Dental, PRSC, SSE and Crisis Supports, must complete semi-annual reports.
2. A Respite Provider Agency must submit a semi-annual progress report to the CM that describes progress on the Action Plan(s) and Desired Outcome(s) when Respite is the only service included in the ISP other than Case Management for an adult age 21 or older.
3. The first semi-annual report will cover the time from the start of the person's ISP year until the end of the subsequent six-month period (180 calendar days) and is due ten calendar days after the period ends (190 calendar days).
4. The second semi-annual report is integrated into the annual report or professional assessment/annual re-evaluation when applicable and is due 14 calendar days prior to the annual ISP meeting.
5. Semi-annual reports must contain at a minimum written documentation of:
  - a. the name of the person and date on each page;
  - b. the timeframe that the report covers;
  - c. timely completion of relevant activities from ISP Action Plans or clinical service goals during timeframe the report is covering;
  - d. a description of progress towards Desired Outcomes in the ISP related to the service provided;

e. a description of progress toward any service specific or treatment goals when applicable (e.g. health related goals for nursing);  
f. significant changes in routine or staffing if applicable;  
g. unusual or significant life events, including significant change of health or behavioral health condition;  
h. the signature of the agency staff responsible for preparing the report; and  
i. any other required elements by service type that are detailed in these standards.

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> <li>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</li> <li>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web-based system using computers or mobile devices is acceptable.</li> <li>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</li> <li>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</li> <li>5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.</li> <li>6. The current Client File Matrix found in Appendix</li> </ol>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 5 of 5 Individuals receiving Living Care Arrangements.</p> <p>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Annual ISP:</b></p> <ul style="list-style-type: none"> <li>• Not Current (#3, 5)</li> </ul> <p><b>ISP Teaching and Support Strategies:</b></p> <p><b>Individual #2:</b> TSS not found for the following Live Outcome Statement / Action Steps:</p> <ul style="list-style-type: none"> <li>• “With staff assistance steps to getting a dog.”</li> <li>• “Purchasing a dog.”</li> </ul> <p><b>Individual #3:</b> TSS not found for the following Live Outcome Statement / Action Steps:</p> <ul style="list-style-type: none"> <li>• “With assistance will research and take community safety class.”</li> <li>• “With assistance will create a safety checklist.”</li> <li>• “Will follow the safety checklist.”</li> </ul> <p><b>Individual #4:</b> TSS not found for the following Live Outcome Statement / Action Steps:</p>	<p><b>New / Repeat Findings:</b></p> <p>Based on the Agency’s Plan of Correction approved on 1/18/2019, “the Master Files would be audited and updated by 2/28/2019 and those files will be used to audit and update the Residential Binder.”</p> <p>No evidence of Residential Binders being updated was provided during the Verification Survey completed on June 28 – July 3, 2019.</p>

A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.  
 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

**20.5.3 Health Passport and Physician Consultation Form:**

All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. Requirements for the Health Passport and Physician Consultation form are:

2. The Primary and Secondary Provider Agencies must ensure that a current copy of the Health Passport and Physician Consultation forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF.

**Chapter 13: Nursing Services:**

**13.2.9 Healthcare Plans (HCP):** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care

- “Staff assistance create a visual cue.”
- “...will independently take a shower.”

**Individual #5:**  
*TSS not found for the following Live Outcome Statement / Action Steps:*

- “With assistance will vacuum bedroom.”

**Individual #6:**  
*TSS not found for the following Live Outcome Statement / Action Steps:*

- “With staff assistance will fold her garment.”
- “With staff assistance will place her garments in drawers.”

**Healthcare Passport:**

- Not Current (#6)

**Comprehensive Aspiration Risk Management Plan:**

- Not Current (#2)

**Medical Emergency Response Plans:**

- Constipation (#6)
- Falls (#2)

**Special Health Care Needs:**

- Nutritional Plan (#3, 5)

planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans.

2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary

**13.2.10 Medical Emergency Response Plan**

**(MERP):** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP.

2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

**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 DDS Individual Case File Matrix policy.

Tag # LS14.1 Residential Service Delivery Site Case File (Other Required Documentation)	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:</b> All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary.</p> <p>DD Waiver Provider Agencies are required to adhere to the following:</p> <ol style="list-style-type: none"> <li>1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service.</li> <li>2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable.</li> <li>3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings.</li> <li>4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated.</li> <li>5. Each Provider Agency is responsible for</li> </ol>	<p>Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 3 of 5 Individuals receiving Living Care Arrangements.</p> <p>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:</p> <p><b>Positive Behavioral Plan:</b></p> <ul style="list-style-type: none"> <li>• Not Current (#2, 5)</li> </ul> <p><b>Speech Therapy Plan (Therapy Intervention Plan):</b></p> <ul style="list-style-type: none"> <li>• Not Found (#5, 6)</li> </ul> <p><b>Occupational Therapy Plan (Therapy Intervention Plan):</b></p> <ul style="list-style-type: none"> <li>• Not Found (#5)</li> <li>• Not Current (#2)</li> </ul>	<p><b>New / Repeat Findings:</b></p> <p>Based on the Agency's Plan of Correction approved on 1/18/2019, the Master Files will be audited and updated by 2/28/2019. Those files will then be used to audit and update the Residential Binder.</p> <p>No evidence of Residential Binders being updated was provided during the Verification Survey completed on June 28 – July 3, 2019.</p>

maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency.

6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community.

7. All records pertaining to JCMs must be retained permanently and must be made available to DDS upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

**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 DDS Individual Case File Matrix policy.

Standard of Care	Routine Survey Deficiencies December 3 – 6, 2018	Verification Survey New and Repeat Deficiencies June 28 – July 3, 2019
<i>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.</i>		
<b>Tag # 1A22 Agency Personnel Competency</b>	<b>Condition of Participation Level Deficiency</b>	<b>Condition of Participation Level Deficiency</b>
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p><b>Chapter 13: Nursing Services 13.2.11 Training and Implementation of Plans:</b>  1. RNs and LPNs are required to provide Individual Specific Training (IST) regarding HCPs and MERPs.  2. The agency nurse is required to deliver and document training for DSP/DSS regarding the healthcare interventions/strategies and MERPs that the DSP are responsible to implement, clearly indicating level of competency achieved by each trainee as described in Chapter 17.10 Individual-Specific Training.</p> <p><b>Chapter 17: Training Requirement 17.10 Individual-Specific Training:</b> The following are elements of IST: defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge, and skill.  Reaching an <b>awareness level</b> may be accomplished by reading plans or other information. The trainee is cognizant of information related to a person's specific condition. Verbal or written recall of basic information or knowing where to access the information can verify awareness.  Reaching a <b>knowledge level</b> may take the form of observing a plan in action, reading a plan more thoroughly, or having a plan described by</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on interview, the Agency did not ensure training competencies were met for 4 of 7 Direct Support Personnel.</p> <p><b>When DSP were asked, if the Individual had a Behavioral Crisis Plan (BCIP), have you been trained on the BCIP and what does the plan cover, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #502 stated, "No Crisis Plan." According to the Individual Specific Training Section of the ISP the Individual requires a Behavioral Crisis Intervention Plan. (Individual #4)</li> </ul> <p><b>When DSP were asked, if the Individual's had Medical Emergency Response Plans and where could they be located, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #506 stated, "Just one for Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Medical Emergency Response Plans for Constipation. (Individual #6)</li> </ul> <p><b>When DSP were asked, when would you call the nurse if the Individual no bowel movement, the following was reported:</b></p> <ul style="list-style-type: none"> <li>• DSP #506 stated, "A week or two." (Individual #6)</li> </ul>	<p><b>Repeat Findings:</b></p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure training competencies were met for 1 of 5 Direct Support Personnel.</p> <p>Per the agencies Plan of Correction "Training of these specific DSPs will take place prior to February 28, 2019."</p> <ul style="list-style-type: none"> <li>• No evidence was provided indicating DSP #502 was retrained on the Behavioral Crisis Intervention Plan. (Individual #4)</li> <li>• No evidence was provided indicating DSP #502 was retrained on ANE. Evidence provided indicated DSP was trained on 8/7/2018, which was prior to the routine survey that took place December 3 - 6, 2018.</li> </ul>

the author or their designee. Verbal or written recall or demonstration may verify this level of competence.

Reaching a **skill level** involves being trained by a therapist, nurse, designated or experienced designated trainer. The trainer shall demonstrate the techniques according to the plan. Then they observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback. Individuals shall receive services from competent and qualified Provider Agency personnel who must successfully complete IST requirements in accordance with the specifications described in the ISP of each person supported.

1. IST must be arranged and conducted at least annually. IST includes training on the ISP Desired Outcomes, Action Plans, strategies, and information about the person's preferences regarding privacy, communication style, and routines. More frequent training may be necessary if the annual ISP changes before the year ends.
2. IST for therapy-related WDSI, HCPs, MERPs, CARMPs, PBSA, PBSP, and BCIP, must occur at least annually and more often if plans change, or if monitoring by the plan author or agency finds incorrect implementation, when new DSP or CM are assigned to work with a person, or when an existing DSP or CM requires a refresher.
3. The competency level of the training is based on the IST section of the ISP.
4. The person should be present for and

**When Direct Support Personnel were asked, what State Agency do you report suspected Abuse, Neglect or Exploitation, the following was reported:**

- DSP #522 stated, "I can't remember." Staff was not able to identify the State Agency as Division of Health Improvement.
- DSP #547 stated, "APS." Staff was not able to identify the State Agency as Division of Health Improvement.

**When DSP were asked to give examples of Abuse, Neglect and Exploitation, the following was reported:**

- DSP #502 stated, "State, I just know it by state."
- DSP #522 stated, "I don't know what Exploitation is."

**When DSP were asked if they are able to report suspected Abuse, Neglect, Exploitation or any other reportable incident, without fear of retaliation from the Agency, the following was reported:**

- DSP [REDACTED] stated, "I was advocating for client that lost a loved one and was told by supervisor to leave it. I mentioned to Case Manager and Case Manager reported to state and I got written up for it."

involved in IST whenever possible.

5. Provider Agencies are responsible for tracking of IST requirements.

6. Provider Agencies must arrange and ensure that DSP's are trained on the contents of the plans in accordance with timelines indicated in the Individual-Specific Training Requirements: Support Plans section of the ISP and notify the plan authors when new DSP are hired to arrange for trainings.

7. If a therapist, BSC, nurse, or other author of a plan, healthcare or otherwise, chooses to designate a trainer, that person is still responsible for providing the curriculum to the designated trainer. The author of the plan is also responsible for ensuring the designated trainer is verifying competency in alignment with their curriculum, doing periodic quality assurance checks with their designated trainer, and re-certifying the designated trainer at least annually and/or when there is a change to a person's plan.

Tag # 1A43.1 General Events Reporting - Individual Reporting	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019</p> <p><b>Chapter 19: Provider Reporting Requirements:</b></p> <p><b>19.2 General Events Reporting (GER):</b> The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSA analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows:</p> <ol style="list-style-type: none"> <li>1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system.</li> <li>2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements.</li> <li>3. At the Provider Agency's discretion additional events, which are not required by DDSA, may also be tracked within the GER section of Therap.</li> <li>4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System.</li> <li>5. GER does not replace a Provider Agency's obligations related to healthcare coordination, modifications to the ISP, or any other risk management and QI activities.</li> </ol>	<p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 3 of 6 individuals.</p> <p><b>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:</b></p> <p><b>Individual #1</b></p> <ul style="list-style-type: none"> <li>• General Events Report (GER) indicates on 1/4/2018 the Individual had a fall. (Fall). GER was approved 1/17/2018.</li> </ul> <p><b>Individual #3</b></p> <ul style="list-style-type: none"> <li>• General Events Report (GER) indicates on 10/24/2018 the Individual was taken to urgent care. (Injury). GER was approved 10/29/2018.</li> <li>• General Events Report (GER) indicates on 12/31/2017 the Individual was taken to hospital. (Hospital stay). GER was approved 1/18/2018.</li> </ul> <p><b>Individual #5</b></p> <ul style="list-style-type: none"> <li>• General Events Report (GER) indicates on 1/15/2018 the Individual had a bruise on neck. (Injury). GER was approved 2/21/2018.</li> </ul>	<p><b>New / Repeat Findings:</b></p> <p>Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 2 of 6 individuals.</p> <p><b>The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and / or approved within 2 business days:</b></p> <p><b>Individual #2</b></p> <ul style="list-style-type: none"> <li>• General Events Report (GER) indicates on 5/1/2019 the Individual had a red sore with an odor on his left underarm. (Skin Abrasion). GER was approved 1/31//2019.</li> </ul> <p><b>Individual #6</b></p> <ul style="list-style-type: none"> <li>• General Events Report (GER) indicates on 2/27/2019 the Individual was taken to urgent care. (Hospital). GER was approved 3/6/2019.</li> </ul>

**Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting:

1. Effective immediately, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau.

2. No alternative methods for reporting are permitted.

**The following events need to be reported in the Therap GER:**

- Emergency Room/Urgent Care/Emergency Medical Services
- Falls Without Injury
- Injury (including Falls, Choking, Skin Breakdown and Infection)
- Law Enforcement Use
- Medication Errors
- Medication Documentation Errors
- Missing Person/Elopement
- Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission
- PRN Psychotropic Medication
- Restraint Related to Behavior
- Suicide Attempt or Threat

Entry Guidance: Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.

Standard of Care	Routine Survey Deficiencies December 3 – 6, 2018	Verification Survey New and Repeat Deficiencies June 28 – July 3, 2019
<b>Service Domain: Health and Welfare</b> - 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.		
<b>Tag # 1A29 Complaints / Grievances – Acknowledgement</b>	<b>Standard Level Deficiency</b>	<b>Standard Level Deficiency</b>
<p><b>NMAC 7.26.3.6</b> A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p><b>NMAC 7.26.3.13 Client Complaint Procedure Available.</b> A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p><b>NMAC 7.26.4.13 Complaint Process:</b> <b>A. (2).</b> The service provider's complaint or grievance procedure shall provide, at a minimum, that: <b>(a)</b> the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 2 of 6 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found and/or incomplete:</p> <p><b>Grievance/Complaint Procedure Acknowledgement:</b></p> <ul style="list-style-type: none"> <li>• Not found (#4, 5)</li> </ul>	<p><b>Repeat Findings:</b></p> <p>Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 2 of 6 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found and/or incomplete:</p> <p><b>Grievance/Complaint Procedure Acknowledgement:</b></p> <ul style="list-style-type: none"> <li>• Not found (#4, 5)</li> </ul>

Tag # 1A31 Client Rights/Human Rights	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
<p><b>NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS:</b></p> <p>A. A service provider shall not restrict or limit a client's rights except:</p> <p>(1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or</p> <p>(2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or</p> <p>(3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC].</p> <p>B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy.</p> <p>C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 2: Human Rights:</b> Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 6 Individuals.</p> <p>No current Human Rights Approval was found for the following:</p> <ul style="list-style-type: none"> <li>• Line of Sight. No evidence found of Human Rights Committee approval (Individual #4)</li> <li>• Use of 911/Law Enforcement. No evidence found of Human Rights Committee approval. (Individual #4)</li> </ul>	<p><b>Repeat Findings:</b></p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 1 of 6 Individuals.</p> <p>No current Human Rights Approval was found for the following:</p> <ul style="list-style-type: none"> <li>• Line of Sight. No evidence found of Human Rights Committee approval (Individual #4)</li> <li>• Use of 911/Law Enforcement. No evidence found of Human Rights Committee approval. (Individual #4)</li> </ul>

violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person.

**Chapter 3 Safeguards: 3.3.1 HRC Procedural Requirements:**

1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative.
2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review.
3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC.
4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting.
5. HRC committees are required to meet at least on a quarterly basis.
6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large.
7. HRC members who are directly involved in the services provided to the person must excuse

themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations.

8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction.

**3.3.3 HRC and Behavioral Support:** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated and used when behavioral support is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be

<p>temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval.</p> <p>Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations.</p> <p><b>3.3.4 Interventions Requiring HRC Review and Approval:</b> HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to:</p> <ol style="list-style-type: none"> <li>1. response cost;</li> <li>2. restitution;</li> <li>3. emergency physical restraint (EPR);</li> <li>4. routine use of law enforcement as part of a BCIP;</li> <li>5. routine use of emergency hospitalization procedures as part of a BCIP;</li> <li>6. use of point systems;</li> <li>7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components;</li> <li>8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons;</li> <li>9. use of PRN psychotropic medications;</li> <li>10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey gloves for biting hand);</li> <li>11. use of bed rails;</li> <li>12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or</li> <li>13. use of any alarms to alert staff to a person's whereabouts.</li> </ol>		
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**3.4 Emergency Physical Restraint (EPR):**

Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety.

**3.4.5 Human Rights Committee:** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs:

1. participate in training regarding required constitution and oversight activities for HRCs;
2. review any BCIP, that include the use of EPR;
3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered;
4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and
5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.

Tag # LS25 Residential Health and Safety (Supported Living & Family Living)	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018</p> <p><b>Chapter 10: Living Care Arrangements (LCA)</b></p> <p><b>10.3.6 Requirements for Each Residence:</b></p> <p>Provider Agencies must assure that each residence is clean, safe, and comfortable, and each residence accommodates individual daily living, social and leisure activities. In addition, the Provider Agency must ensure the residence:</p> <ol style="list-style-type: none"> <li>1. has basic utilities, i.e., gas, power, water, and telephone;</li> <li>2. has a battery operated or electric smoke detectors or a sprinkler system, carbon monoxide detectors, and fire extinguisher;</li> <li>3. has a general-purpose first aid kit;</li> <li>4. has accessible written documentation of evacuation drills occurring at least three times a year overall, one time a year for each shift;</li> <li>5. has water temperature that does not exceed a safe temperature (1100 F);</li> <li>6. has safe storage of all medications with dispensing instructions for each person that are consistent with the Assistance with Medication (AWMD) training or each person's ISP;</li> <li>7. has an emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy;</li> <li>8. has emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding;</li> <li>9. supports environmental modifications and assistive technology devices, 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;</li> <li>10. has or arranges for necessary equipment for bathing and transfers to support health and</li> </ol>	<p>Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 5 of 5 Living Care Arrangement residences.</p> <p>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:</p> <p><b>Supported Living Requirements:</b></p> <ul style="list-style-type: none"> <li>• Carbon monoxide detectors (#2, 3, 5, 6)</li> <li>• Fire extinguisher (#3)</li> <li>• General-purpose first aid kit (#5)</li> <li>• Water temperature in home does not exceed safe temperature (110° F) <ul style="list-style-type: none"> <li>• Water temperature in home measured 139.4° F (#2)</li> <li>• Water temperature in home measured 145.3° F (#3)</li> <li>• Water temperature in home measured 124.6° F (#4)</li> <li>• Water temperature in home measured 117° F (#5)</li> <li>• Water temperature in home measured 138° F (#6)</li> </ul> </li> <li>• Emergency evacuation procedures that address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3, 6)</li> </ul>	<p><b>Repeat Findings:</b></p> <p>Based on record review, the Agency did not ensure that each individuals' residence met all requirements within the standard for 1 of 5 Living Care Arrangement residences.</p> <p>Review of the residential records revealed the following items were not found, not functioning or incomplete:</p> <ul style="list-style-type: none"> <li>• Water temperature in home does not exceed safe temperature (120° F) <ul style="list-style-type: none"> <li>• Water temperature in home measured 123° F per the home checklist sheet for 6/10/2019. The following are the dates of previous home checklists with the corresponding temperatures: 3/18/2018-149.8° F, 4/4/2019-150° F 4/18/2019-150.9° F, 5/17/2019-149.8° F, 5/31/2019- 149.8° F. (#2)</li> </ul> </li> </ul>

safety with consultation from therapists as needed;

11. has the phone number for poison control within line of site of the telephone;
12. has general household appliances, and kitchen and dining utensils;
13. has proper food storage and cleaning supplies;
14. has adequate food for three meals a day and individual preferences; and
15. has at least two bathrooms for residences with more than two residents.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015

**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:

- 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;
- c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;
- d. Have a general-purpose first aid kit;
- 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;

- Emergency placement plan for relocation of people in the event of an emergency evacuation that makes the residence unsuitable for occupancy (#2, 3, 4, 6)

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.

Standard of Care	Routine Survey Deficiencies December 3 – 6, 2018	Verification Survey New and Repeat Deficiencies June 28 – July 3, 2019
<b>Service Domain: Service Plans: ISP Implementation</b> - Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.		
Tag # 1A08 Administrative Case File (Other Required Documents)	Standard Level Deficiency	COMPLETE
Tag # 1A08.1 Administrative and Residential Case File: Progress Notes	Standard Level Deficiency	COMPLETE
Tag # 1A08.3 Administrative Case File: Individual Service Plan/ISP Components	Condition of Participation Level Deficiency	COMPLETE
<b>Service Domain: Qualified Providers</b> - The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.		
Tag # 1A20 Direct Support Personnel Training	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A25 and 1A25.1 Caregiver Criminal History Screening	Standard Level Deficiency	COMPLETE
Tag # 1A26 and 1A26.1 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency	COMPLETE
Tag # 1A37 Individual Specific Training	Condition of Participation Level Deficiency	COMPLETE
<b>Service Domain: Health and Welfare</b> - The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.		
Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A09 Medication Delivery - Routine Medication Administration	Condition of Participation Level Deficiency	COMPLETE
Tag # 1A09.0 Medication Delivery Routine Medication Administration	Standard Level Deficiency	COMPLETE
Tag # 1A15.2 Administrative Case File: Healthcare Documentation (Therap and Required Plans)	Condition of Participation Level Deficiency	COMPLETE

<b>Tag # 1A33.1 Board of Pharmacy – License</b>	<b>Standard Level Deficiency</b>	<b>COMPLETE</b>
<i>Service Domain: Medicaid Billing/Reimbursement - State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</i>		
<b>Tag # IS25 Community Integrated Employment Services / Supported Employment Reimbursement</b>	<b>Standard Level Deficiency</b>	<b>COMPLETE</b>
<b>Tag # IS30 Customized Community Supports Reimbursement</b>	<b>Standard Level Deficiency</b>	<b>COMPLETE</b>
<b>Tag # LS26 Supported Living Reimbursement</b>	<b>Standard Level Deficiency</b>	<b>COMPLETE</b>











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Date: September 4, 2019

To: Kimber Crowe, Executive Director  
Provider: Tohatchi Area of Opportunity & Services, Inc.  
Address: 1658 S. 2nd Street  
City, State, Zip: Gallup, New Mexico 87301

E-mail Address: [kimber.crowe@taos-inc.org](mailto:kimber.crowe@taos-inc.org)

Region: Northwest  
Routine Survey: December 3 - 6, 2018  
Verification Survey: June 28 – July 3, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012 & 2018:** Supported Living, Customized Community Supports,  
Community Integrated Employment Services

Survey Type: Verification

Dear Kimber Crowe;

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

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