SUSANA MARTINEZ, GOVERNOR



RETTA WARD, CABINET SECRETARY

Date: August 20, 2015

To: James McDonald, Executive Director Provider: Animas Valley Caring Hands, LLC

Address: P.O. Box 150

State/Zip: Farmington, New Mexico 87499

E-mail Address: avchnm@yahoo.com

Region: Northwest

Survey Date: June 15 - 17, 2015

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Family Living); Inclusion Supports (Customized Community Supports)

and Other (Customized In-Home Supports)

Survey Type: Routine

Team Leader: Richard A. Reyes Jr., BS, Healthcare Surveyor, Division of Health Improvement/Quality

Management Bureau

Team Members: Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management

Bureau; Stephanie Roybal, BA, Healthcare Surveyor, Division of Health Improvement/Quality

Management Bureau and Jesus Trujillo, RN, Healthcare Surveyor, Division of Health

Improvement/Quality Management Bureau

Dear Mr. McDonald;

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

Determination of Compliance:

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

Compliance with all Conditions of Participation.

This determination is based on your agency's compliance with CMS waiver assurances at the Condition of Participation level. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

Plan of Correction:

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

DIVISION OF HEALTH IMPROVEMENT

5301 Central Avenue NE, Suite 400 • Albuquerque, New Mexico • 87108 (505) 222-8623 • FAX: (505) 222-8661 • http://www.dhi.health.state.nm.us

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Submission of your Plan of Correction:

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

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

- 1. Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed

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

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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

Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Richard A. Reyes Ur., BS

Richard A. Reyes Jr., BS Team Lead/Healthcare Surveyor Division of Health Improvement Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: June 15, 2015

Present: Animas Valley Caring Hands, LLC

James McDonald, Executive Director

DOH/DHI/QMB

Richard A. Reyes Jr. BS, Team Lead/Healthcare Surveyor

Stephanie Roybal, BA, Healthcare Surveyor Jesus Trujillo, RN, Healthcare Surveyor

Exit Conference Date: June 17, 2015

Present: Animas Valley Caring Hands, LLC

James McDonald, Executive Director

DOH/DHI/QMB

Richard A. Reyes Jr. BS, Team Lead/Healthcare Surveyor

Stephanie Roybal, BA, Healthcare Surveyor Jesus Trujillo, RN, Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor

DDSD - NW Regional Office

Michelle Groblebe, Social and Community Service Coordinator

Allison Byrens, DDSD Nurse Crystal Wright, Regional Director

Administrative Locations Visited Number: 1

Total Sample Size Number: 11

0 - Jackson Class Member

11 - Non-Jackson Class Members

6 - Family Living

5 - Customized Community Supports

4 - Customized In-Home Supports

Total Homes Visited Number: 6

Family Living Homes Visited Number: 6

Persons Served Records Reviewed Number: 11

Persons Served Interviewed Number: 9

Persons Served Observed Number: 2 (2 Individuals were not available for interview during

on-site survey).

Direct Support Personnel Interviewed Number: 13

Direct Support Personnel Records Reviewed Number: 37

Substitute Care/Respite Personnel

Records Reviewed Number: 12

Service Coordinator Records Reviewed Number: 1

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Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Individual Medical and Program Case Files, including, but not limited to:
 - o Individual Service Plans
 - o Progress on Identified Outcomes
 - o 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 MFEAD – NM Attorney General

Attachment A

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

Introduction:

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

Required Content

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

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

The Plan of Correction must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

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

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

The following details should be considered when developing your Plan of Correction:

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

- 1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
- 2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
- 3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office
- 4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
 - a. Electronically at AmandaE.Castaneda@state.nm.us (preferred method)
 - b. Fax to 575-528-5019, or
 - c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001
- 5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
- 6. QMB will notify you when your POC has been "approved" or "denied."
 - a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.

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- b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
- c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
- d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
- e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
- Failure to submit your POC within 10 business days without prior approval of an extension by QMB will
 result in a referral to the Internal Review Committee and the possible implementation of monetary
 penalties and/or sanctions.

POC Document Submission Requirements

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

- 1. Your internal documents are due within a <u>maximum</u> of 45 business days of receipt of your Report of Findings.
- 2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
- 3. All submitted documents <u>must be annotated</u>; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
- 4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
- 5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
- 6. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
 - Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
 - Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all
 unjustified units identified and submitted for payment during your internal audit.

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

Attachment B

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

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

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

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

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

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

- Qualified Provider
- Plan of Care
- Health, Welfare and Safety

Conditions of Participation (CoPs)

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

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

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

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

Service Domain: Level of Care

Condition of Participation:

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

Service Domain: Plan of Care

Condition of Participation:

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

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Plan of Care

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

Providers receiving a <u>repeat</u> determination of Non-Compliance will be referred by Quality Management Bureau to the Internal Review Committee (IRC) for consideration of remedies and possible actions or sanctions.

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: Animas Valley Caring Hands LLC - Northwest Region

Program: Developmental Disabilities Waiver

Service: 2012: Living Supports (Supported Living); Inclusion Supports (Customized Community Supports) and Other

(Customized In-Home Supports)

Monitoring Type: Routine Survey
Survey Date: June 15 - 17, 2015

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Im	plementation - Services are delivered in	accordance with the service plan, including	type,
scope, amount, duration and frequency s	pecified in the service plan.		
Tag # 1A08	Standard Level Deficiency		
Agency Case File	·		
Agency Case File Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD; 2. Career Development Plans as incorporated in the ISP; and 3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR). Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 5 of 11 individuals. Review of the Agency Individual case files revealed the following items were not found, incomplete, and/or not current: • ISP budget forms MAD 046 ° Not Current (#1, 2, 9) (No POC required as budget is delayed due to Third Party Assessor) • ISP Signature Page (#3) • Positive Behavioral Support Plan (#5, 9) • Speech Therapy Plan (#1) • Documentation of Guardianship/Power of Attorney (#3, 9)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.		
Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.		
Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.		
Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.		
Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items) • Emergency contact information; • Personal identification; • ISP budget forms and budget prior authorization;		

 ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI); · Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay; Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; Written consent by relevant health decision maker and primary care practitioner for selfadministration of medication or assistance with medication from DSP as applicable: Progress notes written by DSP and nurses; • Signed secondary freedom of choice form; • Transition Plan as applicable for change of provider in past twelve (12) months. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release:** Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications: A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain

records for individuals served through DD Waiver in accordance with the Individual Case File Matrix

incorporated in this director's release.

H. Readily accessible electronic records are	
accessible, including those stored through the	
Therap web-based system.	
Developmental Disabilities (DD) Waiver Service	
Standards effective 4/1/2007	
CHAPTER 1 II. PROVIDER AGENCY	
REQUIREMENTS: D. Provider Agency Case	
File for the Individual: All Provider Agencies	
shall maintain at the administrative office a	
confidential case file for each individual. Case	
records belong to the individual receiving	
services and copies shall be provided to the	
receiving agency whenever an individual	
changes providers. The record must also be	
made available for review when requested by	
DOH, HSD or federal government	
representatives for oversight purposes. The	
individual's case file shall include the following	
requirements:	
(1) Emergency contact information, including the	
individual's address, telephone number,	
names and telephone numbers of relatives,	
or guardian or conservator, physician's	
name(s) and telephone number(s), pharmacy	
name, address and telephone number, and	
health plan if appropriate;	
(2) The individual's complete and current ISP,	
with all supplemental plans specific to the	
individual, and the most current completed	
Health Assessment Tool (HAT);	
(3) Progress notes and other service delivery	
documentation;	
(4) Crisis Prevention/Intervention Plans, if there	
are any for the individual;	
(5) A medical history, which shall include at least	
demographic data, current and past medical	
diagnoses including the cause (if known) of	
the developmental disability, psychiatric	
diagnoses, allergies (food, environmental,	
medications), immunizations, and most	
recent physical exam;	

(6) When applicable, transition plans completed		
for individuals at the time of discharge from		
Fort Stanton Hospital or Los Lunas Hospital		
and Training School; and		
(7) Case records belong to the individual		
receiving services and copies shall be		
provided to the individual upon request.		
(8) The receiving Provider Agency shall be		
provided at a minimum the following records		
whenever an individual changes provider		
agencies:		
(a) Complete file for the past 12 months;		
(b) ISP and quarterly reports from the current		
and prior ISP year;		
(c) Intake information from original admission		
to services; and		
(d) When applicable, the Individual		
Transition Plan at the time of discharge		
from Los Lunas Hospital and Training		
School or Ft. Stanton Hospital.		
NMAC 8.302.1.17 RECORD KEEPING AND		
DOCUMENTATION REQUIREMENTS: A		
provider must maintain all the records necessary		
to fully disclose the nature, quality, amount and		
medical necessity of services furnished to an		
eligible recipient who is currently receiving or		
who has received services in the past.		
who had received conviced in the pact.		
B. Documentation of test results: Results of		
tests and services must be documented, which		
includes results of laboratory and radiology		
procedures or progress following therapy or		
treatment.		

Tag # 1A32 and LS14 / 6L14	Standard Level Deficiency		
Individual Service Plan Implementation			
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines	Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan.	ISP for each stated desired outcomes and action plan for 4 of 11 individuals. As indicated by Individuals ISP the following was		
C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining	found with regards to the implementation of ISP Outcomes:		
desired outcomes. The IDT develops an ISP based upon the individual's personal vision	Administrative Files Reviewed:		
statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to	Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:	Provider:	
reflect progress towards personal goals and achievements consistent with the individual's	Individual #6	Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on	According to the Live Outcome; Action Step for "Practice with karaoke machine" is to be applied 1 time per week, evidence found	number nere. →	
the accreditation of rehabilitation facilities (CARF) and/or other program accreditation	completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP		
approved and adopted by the developmental disabilities division and the department of health.	for 4/2015 - 5/2015.		
It is the policy of the developmental disabilities	Individual #7		
division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage	 According to the Live Outcome; Action Step for "Will find pictures of healthy food alternatives" is to be completed 1 time per 		
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,	week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2015 - 4/2015.		
training, education and/or treatment as determined by the IDT and documented in the ISP.	 None found regarding: Live Outcome; Action Step: "Will find pictures of healthy food alternatives" for 5/2015. 		
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	 According to the Fun Outcome; Action Step for "I will take pictures, collect pictures and or items for my book" is to be completed 1 		

time per week, evidence found indicated it purpose in planning for individuals with developmental disabilities. was not being completed at the required [05/03/94; 01/15/97; Recompiled 10/31/01] frequency as indicated in the ISP for 3/2015 - 4/2015. • None found regarding: Fun Outcome; Action Step: "I will take pictures, collect pictures and or items for my book" for 5/2015. **Customized Community Supports Data** Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #4 According to the Fun Outcome; Action Step for "With staff assistance, will volunteer 24 hours of her time" is to be completed 2 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 4/2015. Individual #6 • None found regarding: Fun Outcome/Action Step: "Choose where he wants to walk" for 5/2015. • None found regarding: Fun Outcome; Action Step: "Walk and keep track of distance" for 5/2015. According to the Work/Learn Outcome; Action Step for "Practice keyboard and songs" is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2015. **Customized In-Home Supports Data** Collection/Data Tracking/Progress with

regards to ISP Outcomes:

Individual #4

 According to the Work/Learn, Outcome; Action Step for "...will do routine" is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/2015.

Residential Files Reviewed:

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

Individual #5

 None found regarding: Live Outcome; Action Step: "Make choices" for 6/1 – 15, 2015.

Individual #7

- According to the Live Outcome; Actions Steps for "Will find pictures of healthy food alternatives" 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 6/1 – 12, 2015.
- According to the Fun Outcome; Action Step for "I will take pictures, collect pictures and or items for my book" 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 6/1 – 12, 2015.
- According to the Fun Outcome; Action Step for "I will work on the pages" 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 6/1 – 12, 2015.

Tog #1 644 / 61 44	Standard Lavel Deficiency		
Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service	Based on record review, the Agency did not	Provider:	
Standards effective 11/1/2012 revised 4/23/2013	maintain a complete and confidential case file in	State your Plan of Correction for the	[]
CHAPTER 11 (FL) 3. Agency Requirements	the residence for 3 of 11 Individuals receiving	deficiencies cited in this tag here: →	
C. Residence Case File: The Agency must	Family Living.	action of the state of the stat	
maintain in the individual's home a complete and			
current confidential case file for each individual.	Review of the residential individual case files		
Residence case files are required to comply with	revealed the following items were not found,		
the DDSD Individual Case File Matrix policy.	incomplete, and/or not current:		
	,		
CHAPTER 12 (SL) 3. Agency Requirements	Current Emergency and Personal		
C. Residence Case File: The Agency must	Identification Information		
maintain in the individual's home a complete and	° None Found (#1)		
current confidential case file for each individual.			
Residence case files are required to comply with	 Positive Behavioral Plan (#1, 5, 7) 		
the DDSD Individual Case File Matrix policy.		Provider:	
	Speech Therapy Plan (#1)	Enter your ongoing Quality Assurance/Quality	
CHAPTER 13 (IMLS) 2. Service Requirements		Improvement processes as it related to this tag	
B.1. Documents To Be Maintained In The		number here: →	
Home:			
a. Current Health Passport generated through			
the e-CHAT section of the Therap website			
and printed for use in the home in case of			
disruption in internet access;			
b. Personal identification;			
c. Current ISP with all applicable assessments,			
teaching and support strategies, and as			
applicable for the consumer, PBSP, BCIP,			
MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans			
(e.g. PRN Psychotropic Medication Plans) as			
applicable;			
d. Dated and signed consent to release			
information forms as applicable;			
e. Current orders from health care practitioners;			
f. Documentation and maintenance of accurate			
medical history in Therap website;			
g. Medication Administration Records for the			
current month:			
h. Record of medical and dental appointments			
for the current year, or during the period of			
for the current year, or during the period of			

stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card: I. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release:** Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications: A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING** SERVICE PROVIDER AGENCY REQUIREMENTS A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving

Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the

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

prescribed;

(d)	Dosage, frequency and method/route of		
	delivery;		
	Times and dates of delivery;		
	Initials of person administering or assisting		
	with medication; and		
(g)	An explanation of any medication		
,,,	irregularity, allergic reaction or adverse		
	effect.		
(h)	For PRN medication an explanation for the		
	use of the PRN must include:		
	(i) Observable signs/symptoms or		
	circumstances in which the medication		
	is to be used, and		
	(ii) Documentation of the		
	effectiveness/result of the PRN		
	delivered.		
	A MAR is not required for individuals		
	participating in Independent Living Services		
	who self-administer their own medication.		
	However, when medication administration		
	is provided as part of the Independent		
	Living Service a MAR must be maintained		
	at the individual's home and an updated		
	copy must be placed in the agency file on a		
	weekly basis.		
	Record of visits to healthcare practitioners		
	ding any treatment provided at the visit and		
	cord of all diagnostic testing for the current		
	year; and		
	Medical History to include: demographic		
	, current and past medical diagnoses		
	ding the cause (if known) of the		
	elopmental disability and any psychiatric		
	nosis, allergies (food, environmental,		
	ications), status of routine adult health care		
	enings, immunizations, hospital discharge		
	maries for past twelve (12) months, past		
	ical history including hospitalizations, eries, injuries, family history and current		
	ical exam.		
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Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Qualified Providers –	The State monitors non-licensed/non-cert	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag	Due
safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) NMAC 7.9.2 F. TRANSPORTATION: (1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance before assisting any resident. The passenger		number here: →	

transportation assistance program shall be		
comprised of but not limited to the following		
elements: resident assessment, emergency		
procedures, supervised practice in the safe		
operation of equipment, familiarity with state		
regulations governing the transportation of persons		
with disabilities, and a method for determining and		
documenting successful completion of the		
course. The course requirements above are		
examples and may be modified as needed.		
(2) Any employee or agent of a regulated facility		
or agency who drives a motor vehicle provided by		
the facility or agency for use in the transportation of		
clients must complete:		
(a) A state approved training program in		
passenger assistance and		
(b) A state approved training program in the		
operation of a motor vehicle to transport clients of		
a regulated facility or agency. The motor vehicle		
transportation assistance program shall be		
comprised of but not limited to the following		
elements: resident assessment, emergency		
procedures, supervised practice in the safe		
operation of motor vehicles, familiarity with state		
regulations governing the transportation of persons		
with disabilities, maintenance and safety record		
keeping, training on hazardous driving conditions		
and a method for determining and documenting		
successful completion of the course. The course		
requirements above are examples and may be		
modified as needed.		
(c) A valid New Mexico driver's license for the		
type of vehicle being operated consistent with		
State of New Mexico requirements.		
(3) Each regulated facility and agency shall		
establish and enforce written polices (including		
training) and procedures for employees who		
provide assistance to clients with boarding or		
alighting from motor vehicles.		
(4) Each regulated facility and agency shall		
establish and enforce written polices (including		
training and procedures for employees who		
operate motor vehicles to transport clients.		

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec.

II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS)

requirements, the services that a provider renders

may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;		

Tag # 1A20	Standard Level Deficiency		
Direct Support Personnel Training	,		
Department of Health (DOH) Developmental	Based on record review, the Agency did not	Provider:	
Disabilities Supports Division (DDSD) Policy -	ensure Orientation and Training requirements	State your Plan of Correction for the	
Policy Title: Training Requirements for Direct	were met for 3 of 37 Direct Support Personnel.	deficiencies cited in this tag here: →	
Service Agency Staff Policy - Eff. March 1, 2007			
- II. POLICY STATEMENTS:	Review of Direct Support Personnel training		
A. Individuals shall receive services from	records found no evidence of the following		
competent and qualified staff.	required DOH/DDSD trainings and certification		
B. Staff shall complete individual-specific (formerly	being completed:		
known as "Addendum B") training requirements in			
accordance with the specifications described in the	Pre- Service (DSP #236)		
individual service plan (ISP) of each individual			
served.	• First Aid (DSP #207)		
C. Staff shall complete training on DOH-approved	- 1 113(711d (DOI 11201)		
incident reporting procedures in accordance with 7 NMAC 1.13.	• CPR (DSP #207)		
D. Staff providing direct services shall complete	• OF R (DSF #201)	Provider:	
training in universal precautions on an annual	Assisting With Madigation Delivery	Enter your ongoing Quality Assurance/Quality	
basis. The training materials shall meet	Assisting With Medication Delivery (DSP #207, 226)	Improvement processes as it related to this tag	
Occupational Safety and Health Administration	(DSF #201, 220)	number here: →	
(OSHA) requirements.			
E. Staff providing direct services shall maintain			
certification in first aid and CPR. The training			
materials shall meet OSHA			
requirements/guidelines.			
F. Staff who may be exposed to hazardous			
chemicals shall complete relevant training in			
accordance with OSHA requirements.			
G. Staff shall be certified in a DDSD-approved			
behavioral intervention system (e.g., Mandt, CPI)			
before using physical restraint techniques. Staff			
members providing direct services shall maintain			
certification in a DDSD-approved behavioral			
intervention system if an individual they support			
has a behavioral crisis plan that includes the use of physical restraint techniques.			
H. Staff shall complete and maintain certification in			
a DDSD-approved medication course in			
accordance with the DDSD Medication Delivery			
Policy M-001.			
I. Staff providing direct services shall complete			
safety training within the first thirty (30) days of			

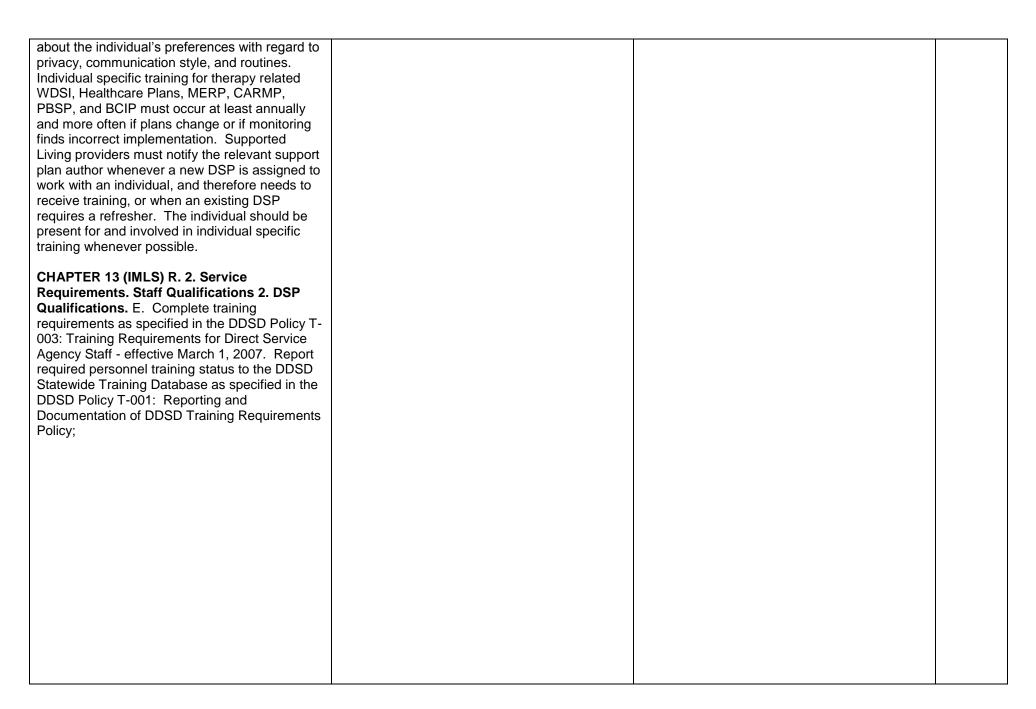
employment and before working alone with an individual receiving service.		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy.		
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;		
CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy		
CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training: A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training		

II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.		
CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;		

	Standard Level Deficiency		
Agency Personnel Competency			
Department of Health (DOH) Developmental	Based on interview, the Agency did not ensure	Provider:	
Disabilities Supports Division (DDSD) Policy	training competencies were met for 2 of 13	State your Plan of Correction for the	
- Policy Title: Training Requirements for	Direct Support Personnel.	deficiencies cited in this tag here: →	
Direct Service Agency Staff Policy - Eff.			
March 1, 2007 - II. POLICY STATEMENTS:	When DSP were asked if the Individual had a		
A. Individuals shall receive services from	Positive Behavioral Supports Plan and if so,		
competent and qualified staff.	what the plan covered, the following was		
B. Staff shall complete individual specific	reported:		
(formerly known as "Addendum B") training			
requirements in accordance with the	 DSP #210 stated, "Not at this time, no…" 		
specifications described in the individual service	According to the Individual Specific Training		
plan (ISP) for each individual serviced.	Section of the ISP, the Individual requires a		
	Positive Behavioral Supports Plan. (Individual		
Developmental Disabilities (DD) Waiver Service	#5)		
Standards effective 11/1/2012 revised 4/23/2013		Provider:	
CHAPTER 5 (CIES) 3. Agency Requirements	When DSP were asked if the Individual had	Enter your ongoing Quality Assurance/Quality	
G. Training Requirements: 1. All Community	an Occupational Therapy Plan and if so, what		
Inclusion Providers must provide staff training in	the plan covered, the following was reported:	number here: →	
accordance with the DDSD policy T-003:			
Training Requirements for Direct Service	 DSP #223 stated, "No." According to the 		
Agency Staff Policy. 3. Ensure direct service	Individual Specific Training ISP, the Individual		
personnel receives Individual Specific Training	requires an Occupational Therapy Plan.		
as outlined in each individual ISP, including	(Individual #7)		
aspects of support plans (healthcare and			
behavioral) or WDSI that pertain to the	When DSP were asked if the Individual had a		
employment environment.	Health Care Plan for Diabetes and if so did		
	they received training on the Individual's		
CHAPTER 6 (CCS) 3. Agency Requirements	Diabetic condition, the following was		
F. Meet all training requirements as follows:	reported:		
1. All Customized Community Supports			
Providers shall provide staff training in	DSP #223 stated, "Yes." DSP acknowledged		
accordance with the DDSD Policy T-003:	there was a plan. However, when asked		
Training Requirements for Direct Service	about the signs of high blood sugar, and what		
Agency Staff Policy;	you are supposed to do when the individual is		
CUADTED 7 (CIUS) 2 Aganou Boquiromanto	experiencing high blood sugar, DSP #223		
CHAPTER 7 (CIHS) 3. Agency Requirements	stated "I'm not sure." According to the		
C. Training Requirements: The Provider	electronic Comprehensive Health		
Agency must report required personnel training status to the DDSD Statewide Training	Assessment tool, the individual has a		
Database as specified in the DDSD Policy T-	diagnosis of diabetes. (Individual #7)		

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

Individual Service Plan outcomes, actions steps		
and strategies and associated support plans		
(e.g. health care plans, MERP, PBSP and BCIP		
etc), information about the individual's		
preferences with regard to privacy,		
communication style, and routines. Individual		
specific training for therapy related WDSI,		
Healthcare Plans, MERPs, CARMP, PBSP, and		
BCIP must occur at least annually and more		
often if plans change or if monitoring finds		
incorrect implementation. Family Living		
providers must notify the relevant support plan		
author whenever a new DSP is assigned to work		
with an individual, and therefore needs to		
receive training, or when an existing DSP		
requires a refresher. The individual should be		
present for and involved in individual specific		
training whenever possible.		
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CHAPTER 12 (SL) 3. Agency Requirements		
B. Living Supports- Supported Living		
Services Provider Agency Staffing		
Requirements: 3. Training:		
A. All Living Supports- Supported Living		
Provider Agencies must ensure staff training in		
accordance with the DDSD Policy T-003: for		
Training Requirements for Direct Service		
Agency Staff. Pursuant to CMS requirements,		
the services that a provider renders may only be		
claimed for federal match if the provider has		
completed all necessary training required by the		
state. All Supported Living provider agencies		
must report required personnel training status to		
the DDSD Statewide Training Database as		
specified in DDSD Policy T-001: Reporting and		
Documentation for DDSD Training		
Requirements.		
B Individual specific training must be arranged		
and conducted, including training on the ISP		
Outcomes, actions steps and strategies,		
associated support plans (e.g. health care plans,		
MERP, PBSP and BCIP, etc), and information		
MERT, I BOT and BOTT, Ctc), and information		



Tag # 1A26	Standard Level Deficiency		
Consolidated On-line Registry			
Employee Abuse Registry			
NMAC 7.1.12.8 REGISTRY ESTABLISHED;	Based on record review, the Agency did not	Provider:	
PROVIDER INQUIRY REQUIRED: Upon the	maintain documentation in the employee's	State your Plan of Correction for the	
effective date of this rule, the department has	personnel records that evidenced inquiry into the	deficiencies cited in this tag here: →	
established and maintains an accurate and	Employee Abuse Registry prior to employment		
complete electronic registry that contains the	for 1 of 50 Agency Personnel.		
name, date of birth, address, social security			
number, and other appropriate identifying	The following Agency personnel records		
information of all persons who, while employed	contained no evidence of the Employee		
by a provider, have been determined by the	Abuse Registry check being completed:		
department, as a result of an investigation of a			
complaint, to have engaged in a substantiated	Service Coordination Personnel (SC):		
registry-referred incident of abuse, neglect or			
exploitation of a person receiving care or	• #237 – Date of hire 12/01/2011. (Note: This		
services from a provider. Additions and updates	employee was cited in the Routine Survey		
to the registry shall be posted no later than two	on June 17 – 19, 2013, however, there still	Provider:	
(2) business days following receipt. Only	is no physical documentation in the	Enter your ongoing Quality Assurance/Quality	
department staff designated by the custodian	employee file to indicate an Abuse Registry	Improvement processes as it related to this tag	
may access, maintain and update the data in the	Check was completed as required).	number here: →	
registry.			
A. Provider requirement to inquire of			
registry. A provider, prior to employing or			
contracting with an employee, shall inquire of			
the registry whether the individual under			
consideration for employment or contracting is listed on the registry.			
B. Prohibited employment. A provider			
may not employ or contract with an individual to			
be an employee if the individual is listed on the			
registry as having a substantiated registry-			
referred incident of abuse, neglect or			
exploitation of a person receiving care or			
services from a provider.			
D. Documentation of inquiry to registry .			
The provider shall maintain documentation in the			
employee's personnel or employment records			
that evidences the fact that the provider made			
an inquiry to the registry concerning that			
employee prior to employment. Such			
documentation must include evidence, based on			

Tag # 1A28.1	Standard Level Deficiency		
Incident Mgt. System - Personnel	Chambara 2010. Domoiono,		
Training			
NMAC 7.1.14 ABUSE, NEGLECT,	Based on record review and interview, the	Provider:	
EXPLOITATION, AND DEATH REPORTING,	Agency did not ensure Incident Management	State your Plan of Correction for the	
TRAINING AND RELATED REQUIREMENTS	Training for 4 of 38 Agency Personnel.	deficiencies cited in this tag here: →	
FOR COMMUNITY PROVIDERS	Training for 1 of 55 / gorley 1 of 55 miles.	denoterroles offed in the tag here.	
TOR COMMISSION TO RECEIVE	Direct Support Personnel (DSP):		
NMAC 7.1.14.9 INCIDENT MANAGEMENT	Incident Management Training (Abuse,		
SYSTEM REQUIREMENTS:	Neglect and Exploitation) (DSP# 207, 213,		
A. General: All community-based service	236)		
providers shall establish and maintain an incident			
management system, which emphasizes the			
principles of prevention and staff involvement.			
The community-based service provider shall			
ensure that the incident management system			
policies and procedures requires all employees			
and volunteers to be competently trained to		Provider:	
respond to, report, and preserve evidence related		Enter your ongoing Quality Assurance/Quality	
to incidents in a timely and accurate manner.		Improvement processes as it related to this tag	
B. Training curriculum: Prior to an employee or		number here: →	
volunteer's initial work with the community-based			
service provider, all employees and volunteers			
shall be trained on an applicable written training			
curriculum including incident policies and			
procedures for identification, and timely reporting			
of abuse, neglect, exploitation, suspicious injury,			
and all deaths as required in Subsection A of			
7.1.14.8 NMAC. The trainings shall be reviewed			
at annual, not to exceed 12-month intervals. The			
training curriculum as set forth in Subsection C of			
7.1.14.9 NMAC may include computer-based			
training. Periodic reviews shall include, at a			
minimum, review of the written training curriculum			
and site-specific issues pertaining to the community-based service provider's facility.			
Training shall be conducted in a language that is			
understood by the employee or volunteer.			
C. Incident management system training			
curriculum requirements:			
(1) The community-based service provider			
shall conduct training or designate a			
Shall conduct training of designate a			

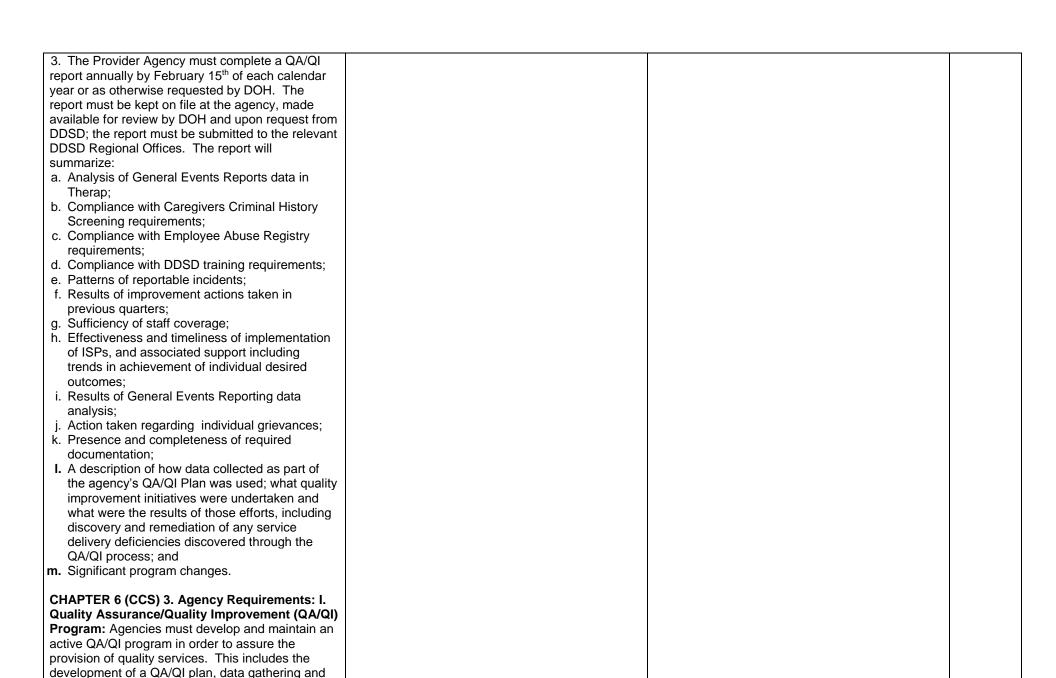
knowledgeable representative to conduct		
training, in accordance with the written training		
curriculum provided electronically by the		
division that includes but is not limited to:		
(a) an overview of the potential risk of		
abuse, neglect, or exploitation;		
(b) informational procedures for properly		
filing the division's abuse, neglect, and		
exploitation or report of death form;		
(c) specific instructions of the employees'		
legal responsibility to report an incident of		
abuse, neglect and exploitation, suspicious		
injury, and all deaths;		
(d) specific instructions on how to respond to		
abuse, neglect, or exploitation;		
(e) emergency action procedures to be		
followed in the event of an alleged incident or		
knowledge of abuse, neglect, exploitation, or		
suspicious injury.		
(2) All current employees and volunteers		
shall receive training within 90 days of the		
effective date of this rule.		
(3) All new employees and volunteers shall		
receive training prior to providing services to		
consumers.		
D. Training documentation: All community-		
based service providers shall prepare training documentation for each employee and volunteer		
to include a signed statement indicating the date,		
time, and place they received their incident		
management reporting instruction. The		
community-based service provider shall maintain		
documentation of an employee or volunteer's		
training for a period of at least three years, or six		
months after termination of an employee's		
employment or the volunteer's work. Training		
curricula shall be kept on the provider premises		
and made available upon request by the		
department. Training documentation shall be		
made available immediately upon a division		
representative's request. Failure to provide		

employee and volunteer training documentation

	T	Ţ	
shall subject the community-based service			
provider to the penalties provided for in this rule.			
provider to the penalties provided for in this fule.			
Policy Title: Training Requirements for Direct			
Service Agency Staff Delicy - Eff March 4			
Service Agency Staff Policy - Eff. March 1,			
2007 II. POLICY STATEMENTS:			
A. Individuals shall receive services from			
competent and qualified staff.			
C. Staff shall complete training on DOH-			
approved incident reporting procedures in			
accordance with 7 NMAC 1.13.			
accordance with 7 NWAC 1.13.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
	als shall be afforded their basic human righ	addresses and seeks to prevent occurrence ats. The provider supports individuals to accepte the provider: State your Plan of Correction for the	
SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include: i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes; iii. The types of information used to measure performance; and, iv. The frequency with which performance is measured.	 Implement their Continuous Quality Management System as required by standard. Review of the Agency's CQI Plan revealed the following: The Agency's CQI Plan did not contain the following components: a. Analysis of General Events Reports data in Therap; b. Compliance with Employee Abuse Registry requirements; c. Results of improvement actions taken in previous quarters; d. Sufficiency of staff coverage; e. Results of General Events Reporting data analysis, Trends in category II significant events; (FL & SL only) 	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service		
Standards effective 11/1/2012 revised 4/23/2013		
CHAPTER 5 (CIES) 3. Agency Requirements: J.		
Quality Assurance/Quality Improvement		
(QA/QI) Program: Agencies must develop and		
maintain an active QA/QI program in order to		
assure the provision of quality services. This		
includes the development of a QA/QI plan, data		
gathering and analysis, and routine meetings to		
analyze the results of QA/QI activities.		
Development of a QA/QI plan: The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements, achieving desired outcomes and identifying opportunities for		
improvement. The quality management plan		
describes the process the Provider Agency uses in		
each phase of the process: discovery, remediation		
and improvement. It describes the frequency, the		
source and types of information gathered, as well		
as the methods used to analyze and measure		
performance. The quality management plan		
should describe how the data collected will be		
used to improve the delivery of services and		
methods to evaluate whether implementation of		
•		
improvements are working.		
2. Implementing a QA/QI Committee: The QA/QI		
committee must convene on at least a quarterly		
basis and as needed to review service reports, to		
identify any deficiencies, trends, patterns or		
concerns as well as opportunities for quality		
improvement. The QA/QI meeting must be		
documented. The QA/QI review should address at		
least the following:		
a. Implementation of ISPs: extent to which		
services are delivered in accordance with ISPs		
and associated support plans with WDSI		
including the type, scope, amount, duration and		
frequency specified in the ISP as well as		
effectiveness of such implementation as		
indicated by achievement of outcomes;		
maloated by achievement of outcomes,		



analysis, and routine meetings to analyze the		
results of QI activities.		
 Development of a QI plan: The quality 		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements, achieving		
desired outcomes and identifying opportunities for		
improvement. The quality management plan		
describes the process the Provider Agency uses in		
each phase of the process: discovery, remediation		
and improvement. It describes the frequency, the		
source and types of information gathered, as well		
as the methods used to analyze and measure		
performance. The quality management plan		
should describe how the data collected will be		
used to improve the delivery of services and		
methods to evaluate whether implementation of		
improvements are working.		
2. Implementing a QI Committee: The QA/QI		
committee shall convene at least quarterly and as		
needed to review service reports, to identify any		
deficiencies, trends, patterns or concerns as well		
as opportunities for quality improvement. The		
QA/QI meeting shall be documented. The QA/QI		
review should address at least the following:		
a. The extent to which services are delivered in		
accordance with ISPs, associated support plans		
and WDSI including the type, scope, amount,		
duration and frequency specified in the ISP as		
well as effectiveness of such implementation as		
indicated by achievement of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History		
Screening requirements;		
d. Compliance with Employee Abuse Registry		
requirements;		
e. Compliance with DDSD training requirements;		
f. Patterns of reportable incidents; and		
g. Results of improvement actions taken in		
previous quarters.		
3. The Provider Agencies must complete a QA/QI		
report annually by February 15th of each year, or as	1	1

otherwise requested by DOH. The report must be			
kept on file at the agency, made available for			
review by DOH and upon request from DDSD the			
report must be submitted to the relevant DDSD			
Regional Offices. The report will summarize:			
a. Sufficiency of staff coverage;			
b. Effectiveness and timeliness of implementation			
of ISPs, associated support plans, and WDSI,			
including trends in achievement of individual			
desired outcomes;			
c. Results of General Events Reporting data			
analysis;			
d. Action taken regarding individual grievances;			
e. Presence and completeness of required			
documentation;			
f. A description of how data collected as part of the			
agency's QI plan was used; what quality			
improvement initiatives were undertaken and			
what were the results of those efforts, including			
discovery and remediation of any service delivery			
deficiencies discovered through the QI process;			
and			
g. Significant program changes.			
CHARTER 7 (CHIS) 2 Agency Requirements: C			
CHAPTER 7 (CIHS) 3. Agency Requirements: G.			
Quality Assurance/Quality Improvement			
(QA/QI) Program: Agencies must develop and			
maintain an active QA/QI program in order to			
assure the provision of quality services. This includes the development of a QA/QI plan, data			
gathering and analysis, and routine meetings to			
analyze the results of QA/QI activities.			
1. Development of a QA/QI plan: The quality			
management plan is used by an agency to			
continually determine whether the agency is			
performing within program requirements, achieving			
desired outcomes and identifying opportunities for			
improvement. The quality management plan			
describes the process the Provider Agency uses in			
each phase of the process: discovery, remediation			
and improvement. It describes the frequency, the			
source and types of information gathered, as well			
as the methods used to analyze and measure			
performance. The quality management plan			
1 7 0 1	I .	I .	

should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.		
2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:		
a. Implementation of ISPs: The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History Screening requirements;		
d. Compliance with Employee Abuse Registry requirements;		
e. Compliance with DDSD training requirements;		
f. Patterns of reportable incidents; and		
g. Results of improvement actions taken in previous quarters.		
3. The Provider Agency must complete a QA/QI report annually by February 15 th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:		

performance. The quality management plan		
should describe how the data collected will be		
used to improve the delivery of services and		
methods to evaluate whether implementation of		
improvements are working.		
2. Implementing a QA/QI Committee: The QA/QI		
committee must convene on at least a quarterly		
basis and as needed to review monthly service		
reports, to identify any deficiencies, trends,		
patterns or concerns as well as opportunities for		
quality improvement. The QA/QI meeting must be		
documented. The QA/QI review should address at		
least the following:		
The extent to which services are delivered in		
accordance with the ISP including the type,		
scope, amount, duration and frequency		
specified in the ISP as well as effectiveness of		
such implementation as indicated by		
achievement of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History		
Screening requirements;		
d. Compliance with Employee Abuse Registry		
requirements;		
e. Compliance with DDSD training requirements;		
f. Patterns in reportable incidents; and g. Results of improvement actions taken in		
previous quarters.		
previous quarters.		
3. The Provider Agency must complete a QA/QI		
report annually by February 15 th of each year, or		
as otherwise requested by DOH. The report must		
be kept on file at the agency, made available for		
review by DOH and upon request from DDSD; the		
report must be submitted to the relevant DDSD		
Regional Offices. The report will summarize:		
a. Sufficiency of staff coverage;		
b. Effectiveness and timeliness of implementation		
of ISPs, including trends in achievement of		
individual desired outcomes;		
c. Results of General Events Reporting data		
analysis, Trends in category II significant		
events;		

d. Patterns in medication errors;		
 e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. A description of how data collected as part of the agency's QI plan was used; h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and i. Significant program changes. 		
CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program: Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.		
2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends,		

patterns, or concerns as well as opportunities for		
quality improvement. The QA/QI meeting must be		
documented. The QA/QI review should address at		
least the following:		
a. Implementation of the ISP and the extent to		
which services are delivered in accordance with		
the ISP including the type, scope, amount,		
duration, and frequency specified in the ISP as		
well as effectiveness of such implementation as		
indicated by achievement of outcomes;		
b. Analysis of General Events Reports data;		
c. Compliance with Caregivers Criminal History		
Screening requirements;		
d. Compliance with Employee Abuse Registry		
requirements;		
e. Compliance with DDSD training requirements;		
f. Patterns in reportable incidents; and		
g. Results of improvement actions taken in		
previous quarters.		
2.The Provider Agency must complete a QA/QI		
report annually by February 15 th of each calendar		
year, or as otherwise requested by DOH. The		
report must be kept on file at the agency, made		
available for review by DOH, and upon request		
from DDSD the report must be submitted to the		
relevant DDSD Regional Offices. The report will		
summarize:		
a. Sufficiency of staff coverage;		
b. Effectiveness and timeliness of implementation		
of ISPs, including trends in achievement of		
individual desired outcomes;		
c. Results of General Events Reporting data		
analysis, Trends in Category II significant		
events;		
d. Patterns in medication errors;		
e. Action taken regarding individual grievances; f. Presence and completeness of required		
documentation;		
g. A description of how data collected as part of		
the agency's QA/QI plan was used, what quality		
improvement initiatives were undertaken and		

the results of those efforts, including discovery and remediation of any service delivery

deficiencies discovered through the QI process;	
and	
n. Significant program changes.	
CHAPTER 13 (IMLS) 3. Service Requirements:	
F. Quality Assurance/Quality Improvement	
QA/QI) Program: Agencies must develop and	
maintain an active QA/QI program in order to	
assure the provision of quality services. This	
ncludes the development of a QA/QI plan, data	
gathering and analysis, and routine meetings to	
analyze the results of QI activities.	
Development of a QI plan: The quality	
management plan is used by an agency to	
continually determine whether the agency is	
performing within program requirements, achieving	
desired outcomes and identifying opportunities for	
mprovement. The quality management plan	
describes the process the Provider Agency uses in	
each phase of the process: discovery, remediation	
and improvement. It describes the frequency, the	
source and types of information gathered, as well	
as the methods used to analyze and measure	
performance. The quality management plan should describe how the data collected will be	
used to improve the delivery of services and	
methods to evaluate whether implementation of	
mprovements are working.	
2. Implementing a QA/QI Committee: The QA/QI	
committee shall convene on at least on a quarterly	
pasis and as needed to review service reports, to	
dentify any deficiencies, trends, patterns or	
concerns, as well as opportunities for quality	
mprovement. For Intensive Medical Living	
providers, at least one nurse shall be a member of	
his committee. The QA meeting shall be	
documented. The QA review should address at	
east the following:	
. Implementation of the ISPs, including the extent	
to which services are delivered in accordance	
with the ISPs and associated support plans and	
/or WDSI including the type, scope, amount,	

duration, and frequency specified in the ISPs as

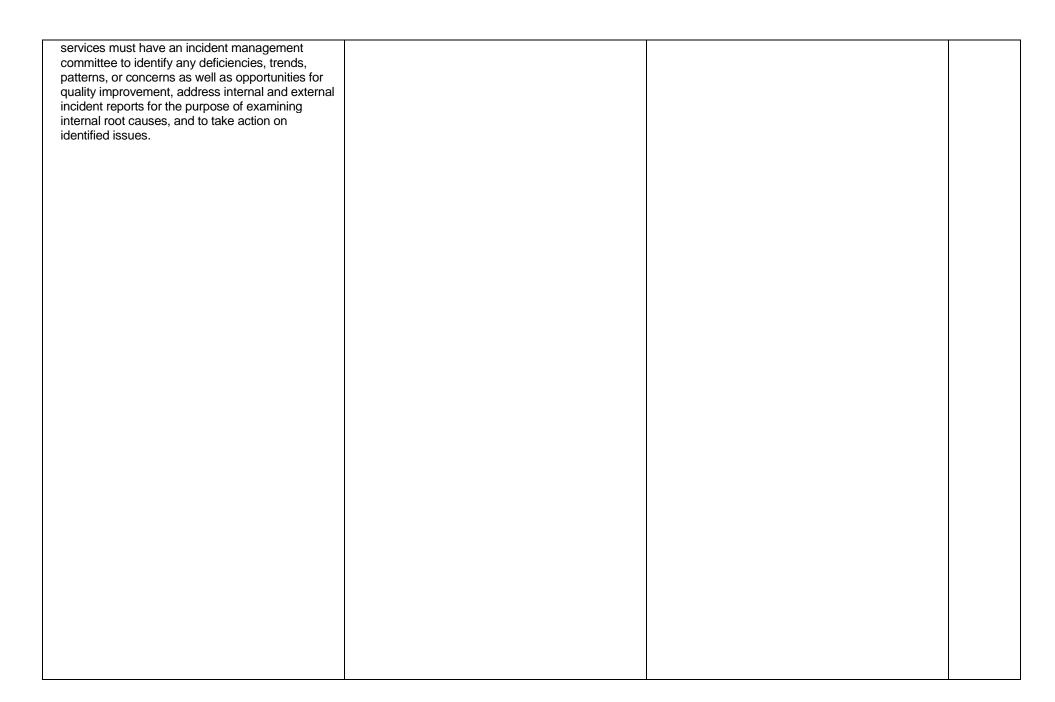
well as effectiveness of such implementation as indicated by achievement of outcomes; b. Trends in General Events as defined by DDSD; c. Compliance with Caregivers Criminal History Screening Requirements; d. Compliance with DDSD training requirements; e. Trends in reportable incidents; and f. Results of improvement actions taken in previous quarters.		
 The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes: Sufficiency of staff coverage; Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes; Trends in reportable incidents; Trends in medication errors; Action taken regarding individual grievances; Presence and completeness of required documentation; How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and Significant program changes. 		
CHAPTER 14 (ANS) 3. Service Requirements: N. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.		

1. Development of a QI plan: The quality		
management plan is used by an agency to		
continually determine whether the agency is		
performing within program requirements, achieving		
desired outcomes and identifying opportunities for		
improvement. The quality management plan		
describes the process the Provider Agency uses in		
each phase of the process: discovery, remediation		
and improvement. It describes the frequency, the		
source and types of information gathered, as well		
as the methods used to analyze and measure		
performance. The quality management plan		
should describe how the data collected will be		
used to improve the delivery of services and		
methods to evaluate whether implementation of		
improvements are working.		
0.1.1.4. 0.1/01.0.14. TI 0.1/01		
2. Implementing a QA/QI Committee: The QA/QI		
committee shall convene on at least on a quarterly		
basis and as needed to review service reports, to		
identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality		
improvement. For Intensive Medical Living		
providers, at least one nurse shall be a member of		
this committee. The QA meeting shall be		
documented. The QA review should address at		
least the following:		
a. Trends in General Events as defined by DDSD;		
b. Compliance with Caregivers Criminal History		
Screening Requirements;		
c. Compliance with DDSD training requirements;		
d. Trends in reportable incidents; and		
e. Results of improvement actions taken in		
previous quarters.		
3. The Provider Agency must complete a QA/QI		
report annually by February 15th of each calendar		
year, or as otherwise requested by DOH. The		
report must be kept on file at the agency, made		
available for review by DOH and upon request from		
DDSD; the report must be submitted to the relevant		
DDSD Regional Offices. The report will		
summarizes:		
a. Sufficiency of staff coverage;		

b. Trends in reportable incidents;		
c. Trends in medication errors;		
d. Action taken regarding individual grievances;		
e. Presence and completeness of required		
documentation;		
f. How data collected as part of the agency's		
QA/QI was used, what quality improvement		
initiatives were undertaken, and what were the		
results of those efforts, including discovery and		
remediation of any service delivery deficiencies discovered through the QI		
process; and		
g. Significant program changes		
g. Significant program changes		
NMAC 7.1.14.8 INCIDENT MANAGEMENT		
SYSTEM REPORTING REQUIREMENTS FOR		
COMMUNITY-BASED SERVICE PROVIDERS:		
F. Quality assurance/quality improvement		
program for community-based service providers:		
The community-based service provider shall		
establish and implement a quality improvement		
program for reviewing alleged complaints and		
incidents of abuse, neglect, or exploitation against		
them as a provider after the division's investigation is		
complete. The incident management program shall		
include written documentation of corrective actions taken. The community-based service provider shall		
take all reasonable steps to prevent further incidents.		
The community-based service provider shall provide		
the following internal monitoring and facilitating		
quality improvement program:		
(1) community-based service providers shall		
have current abuse, neglect, and exploitation		
management policy and procedures in place that		
comply with the department's requirements;		
(2) community-based service providers		
providing intellectual and developmental disabilities		
services must have a designated incident		
management coordinator in place; and		

(3) community-based service providers

providing intellectual and developmental disabilities



Tag # 1A09	Standard Level Deficiency		
Medication Delivery	, and the second		
Routine Medication Administration			
NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, including over-the-counter medications. This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff	Medication Administration Records (MAR) were reviewed for the months of May and June 2015. Based on record review, 1 of 11 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #7 May 2015 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: Risperidone 2mg ½ Tablet (3 times daily) – Blank 5/19 (5:00 PM)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
administering medications. Model Custodial Procedure Manual D. Administration of Drugs Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: > symptoms that indicate the use of the medication, > exact dosage to be used, and > the exact amount to be used in a 24 hour period.			

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8. Providing assistance with medication delivery as outlined in the ISP; C. Individual Community Integrated Employment 3. Providing assistance with medication delivery as outlined in the ISP; D. Group Community Integrated Employment 4. Providing assistance with medication delivery as outlined in the ISP; and B. Community Integrated Employment Agency Staffing Requirements: o. Comply with DDSD Medication Assessment and Delivery Policy and Procedures;		
CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. C. Small Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. D. Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy.		
CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services: The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): 19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of		

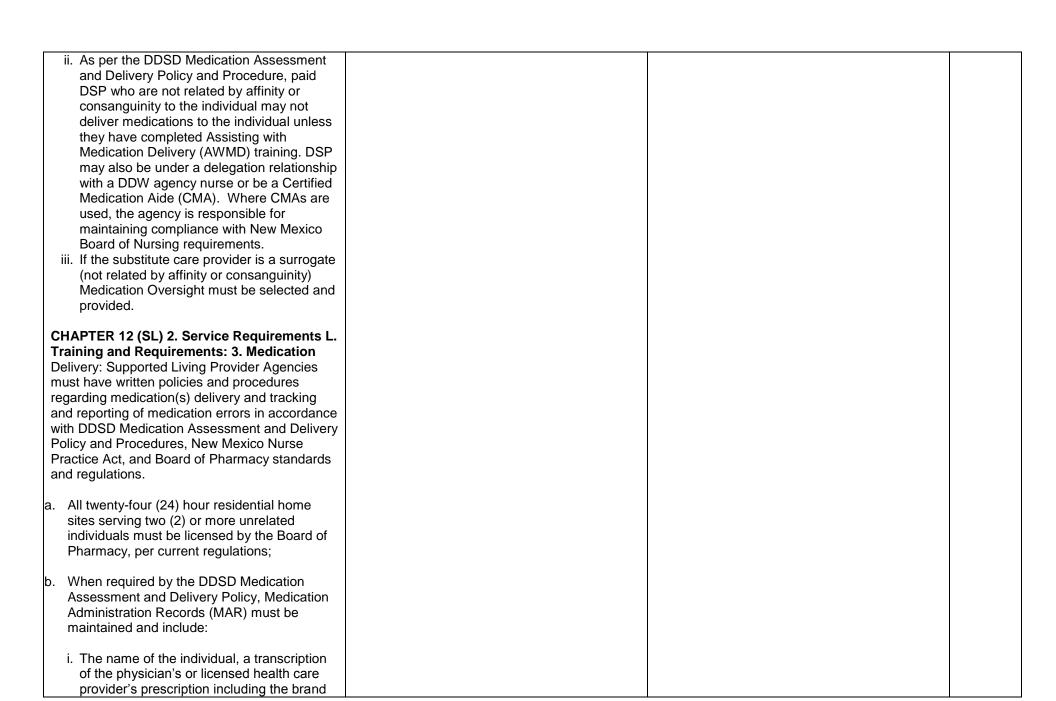
Pharmacy regulations including skill

development activities leading to the ability for

individuals to self-administer medication as		
appropriate; and		
I. Healthcare Requirements for Family Living.		
3. B. Adult Nursing Services for medication		
oversight are required for all surrogate Lining		
Supports- Family Living direct support personnel		
if the individual has regularly scheduled		
medication. Adult Nursing services for		
medication oversight are required for all		
surrogate Family Living Direct Support		
Personnel (including substitute care), if the		
individual has regularly scheduled medication.		
6. Support Living- Family Living Provider		
Agencies must have written policies and		
procedures regarding medication(s) delivery and		
tracking and reporting of medication errors in		
accordance with DDSD Medication Assessment		
and Delivery Policy and Procedures, the New		
Mexico Nurse Practice Act and Board of		
Pharmacy standards and regulations.		
a. All twenty-four (24) hour residential home		
sites serving two (2) or more unrelated		
individuals must be licensed by the Board of		
Pharmacy, per current regulations;		
 b. When required by the DDSD Medication 		
Assessment and Delivery Policy, Medication		
Administration Records (MAR) must be		
maintained and include:		
i.The name of the individual, a transcription of		
the physician's or licensed health care		
provider's prescription including the brand		
and generic name of the medication, and		
diagnosis for which the medication is		
prescribed;		
ii.Prescribed dosage, frequency and		
method/route of administration, times and		
dates of administration;		
iii.Initials of the individual administering or		
assisting with the medication delivery;		
iv.Explanation of any medication error;		

١	v.Documentation of any allergic reaction or	
	adverse medication effect; and	
٧	i.For PRN medication, instructions for the use	
	of the PRN medication must include	
	observable signs/symptoms or	
	circumstances in which the medication is to	
	be used, and documentation of effectiveness	
	of PRN medication administered.	
c.	The Family Living Provider Agency must	
	also maintain a signature page that	
	designates the full name that corresponds to	
	each initial used to document administered	
	or assisted delivery of each dose; and	
d.		
	regarding medications must be kept in the	
	home and community inclusion service	
	locations and must include the expected	
	desired outcomes of administering the	
	medication, signs and symptoms of adverse	
	events and interactions with other	
	medications.	
e.	Medication Oversight is optional if the	
	individual resides with their biological family	
	(by affinity or consanguinity). If Medication	
	Oversight is not selected as an Ongoing	
	Nursing Service, all elements of medication	
	administration and oversight are the sole	
	responsibility of the individual and their	
	biological family. Therefore, a monthly	
	medication administration record (MAR) is	
	not required unless the family requests it	
	and continually communicates all medication	
	changes to the provider agency in a timely	
	manner to insure accuracy of the MAR.	
	i. The family must communicate at least	
	annually and as needed for significant	
	change of condition with the agency nurse	
	regarding the current medications and the	
	individual's response to medications for	
	purpose of accurately completing required	

nursing assessments.



and generic name of the medication, and diagnosis for which the medication is prescribed;	
 ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; 	
iii. Initials of the individual administering or assisting with the medication delivery;	
iv. Explanation of any medication error;	
v. Documentation of any allergic reaction or adverse medication effect; and	
vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.	
c. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and	
d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications.	
CHAPTER 13 (IMLS) 2. Service Requirements. B. There must be compliance with all policy requirements for Intensive Medical	

Living Service Providers, including written poli		
and procedures regarding medication delivery		
and tracking and reporting of medication error		
consistent with the DDSD Medication Delivery		
Policy and Procedures, relevant Board of		
Nursing Rules, and Pharmacy Board standard and regulations.	is	
and regulations.		
Developmental Disabilities (DD) Waiver		
Service Standards effective 4/1/2007		
CHAPTER 1 II. PROVIDER AGENCY		
REQUIREMENTS:		
E. Medication Delivery: Provider		
Agencies that provide Community Living,		
Community Inclusion or Private Duty Nursing		
services shall have written policies and		
procedures regarding medication(s) delivery and tracking and reporting of medication error	6	
in accordance with DDSD Medication	5	
Assessment and Delivery Policy and		
Procedures, the Board of Nursing Rules and		
Board of Pharmacy standards and regulations		
-		
(2) When required by the DDSD Medication		
Assessment and Delivery Policy, Medication		
Administration Records (MAR) shall be		
maintained and include: (a) The name of the individual, a		
transcription of the physician's written of	or	
licensed health care provider's		
prescription including the brand and		
generic name of the medication,		
diagnosis for which the medication is		
prescribed;		
(b) Prescribed dosage, frequency and		
method/route of administration, times		
and dates of administration;		
(c) Initials of the individual administering o	^r	
assisting with the medication;		
(d) Explanation of any medication		

irregularity;

(e) Documentation of any allergic reaction		
or adverse medication effect; and		
(f) For PRN medication, an explanation for		
the use of the PRN medication shall		
include observable signs/symptoms or circumstances in which the medication		
is to be used, and documentation of		
effectiveness of PRN medication		
administered.		
(3) The Provider Agency shall also maintain a		
signature page that designates the full name		
that corresponds to each initial used to		
document administered or assisted delivery of		
each dose;		
(4) MARs are not required for individuals		
participating in Independent Living who self-		
administer their own medications; (5) Information from the prescribing pharmacy		
regarding medications shall be kept in the		
home and community inclusion service		
locations and shall include the expected		
desired outcomes of administrating the		
medication, signs and symptoms of adverse		
events and interactions with other medications;		

Tag # 1A09.1	Standard Level Deficiency		
Medication Delivery	Standard Level Deliciency		
PRN Medication Administration			
	Mar Parties A Indiator Con Decreto (MAAD)	Dura Mari	
NMAC 16.19.11.8 MINIMUM STANDARDS:	Medication Administration Records (MAR) were	Provider:	
A. MINIMUM STANDARDS FOR THE	reviewed for the months of May 2015 and June,	State your Plan of Correction for the	
DISTRIBUTION, STORAGE, HANDLING AND	2015.	deficiencies cited in this tag here: →	
RECORD KEEPING OF DRUGS:			
(d) The facility shall have a Medication	Based on record review, 1 of 11 individuals had		
Administration Record (MAR) documenting	PRN Medication Administration Records (MAR),		
medication administered to residents,	which contained missing elements as required		
including over-the-counter medications.	by standard:		
This documentation shall include:			
(i) Name of resident;	Individual #8		
(ii) Date given;	May 2015		
(iii) Drug product name;	During on-site survey Medication		
(iv) Dosage and form;	Administration Records were requested for		
(v) Strength of drug;	month of May 2015. As of 6/17/2015,		
(vi) Route of administration;	Medication Administration Records for May	Provider:	
(vii) How often medication is to be taken;	2015 had not been provided.	Enter your ongoing Quality Assurance/Quality	
(viii) Time taken and staff initials;		Improvement processes as it related to this tag	
(ix) Dates when the medication is	During on-site survey Physician Orders were	number here: →	
discontinued or changed;	requested. As of 6/17/2015, Physician Orders		
(x) The name and initials of all staff	had not been provided.		
administering medications.			
Model Custodial Procedure Manual			
D. Administration of Drugs			
Unless otherwise stated by practitioner,			
patients will not be allowed to administer their			
own medications.			
Document the practitioner's order authorizing			
the self-administration of medications.			
All PRN (As needed) medications shall have			
complete detail instructions regarding the			
administering of the medication. This shall			
include:			
symptoms that indicate the use of the			
medication,			
exact dosage to be used, and			
the exact amount to be used in a 24			
hour period.			

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

F. PRN Medication

- 3. Prior to self-administration, selfadministration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual.
- 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy).

H. Agency Nurse Monitoring

1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's

diagnoses, health status, stability, utilization of		
PRN medications and level of support required		
by the individual's condition and the skill level		
and needs of the direct care staff. Nursing		
monitoring should be based on prudent nursing		
practice and should support the safety and		
independence of the individual in the		
community setting. The health care plan shall		
reflect the planned monitoring of the		
individual's response to medication.		
Department of Health Developmental		
Disabilities Supports Division (DDSD) -		
Procedure Title:		
Medication Assessment and Delivery		
Procedure Eff Date: November 1, 2006		
C. 3. Prior to delivery of the PRN, direct		
support staff must contact the agency nurse to		
describe observed symptoms and thus assure		
that the PRN is being used according to		
instructions given by the ordering PCP. In		
cases of fever, respiratory distress (including		
coughing), severe pain, vomiting, diarrhea,		
change in responsiveness/level of		
consciousness, the nurse must strongly		
consider the need to conduct a face-to-face		
assessment to assure that the PRN does not		
mask a condition better treated by seeking		
medical attention. (References: Psychotropic		
Medication Use Policy, Section D, page 5 Use		
of PRN Psychotropic Medications; and, Human		
Rights Committee Requirements Policy,		
Section B, page 4 Interventions Requiring		
Review and Approval – Use of PRN		
Medications).		
a. Document conversation with nurse including		
all reported signs and symptoms, advice given		
and action taken by staff.		
4. Document on the MAR each time a PRN		

medication is used and describe its effect on

the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).		
the dame, improved, or wordened, etc.).		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013		
CHAPTER 11 (FL) 1 SCOPE OF SERVICES		
A. Living Supports- Family Living Services: The scope of Family Living Services includes,		
but is not limited to the following as identified by		
the Interdisciplinary Team (IDT): 19. Assisting in medication delivery, and related		
monitoring, in accordance with the DDSD's		
Medication Assessment and Delivery Policy,		
New Mexico Nurse Practice Act, and Board of		
Pharmacy regulations including skill		
development activities leading to the ability for		
individuals to self-administer medication as		
appropriate; and		
I. Healthcare Requirements for Family Living.		
3. B. Adult Nursing Services for medication		
oversight are required for all surrogate Lining		
Supports- Family Living direct support personnel		
if the individual has regularly scheduled		
medication. Adult Nursing services for		
medication oversight are required for all		
surrogate Family Living Direct Support		
Personnel (including substitute care), if the		
individual has regularly scheduled medication.		
6. Support Living- Family Living Provider		
Agencies must have written policies and		
procedures regarding medication(s) delivery and		
tracking and reporting of medication errors in		
accordance with DDSD Medication Assessment		
and Delivery Policy and Procedures, the New		
Mexico Nurse Practice Act and Board of		
Pharmacy standards and regulations.		
f. All twenty-four (24) hour residential home		
sites serving two (2) or more unrelated		

g.	individuals must be licensed by the Board of Pharmacy, per current regulations; When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:		
	i.The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii.Prescribed dosage, frequency and method/route of administration, times and		
	dates of administration;		
i	ii.Initials of the individual administering or		
	assisting with the medication delivery;		
	v.Explanation of any medication error; v.Documentation of any allergic reaction or		
	adverse medication effect; and		
\	vi.For PRN medication, instructions for the use		
	of the PRN medication must include		
	observable signs/symptoms or		
	circumstances in which the medication is to		
	be used, and documentation of effectiveness		
	of PRN medication administered.		
h	The Family Living Provider Agency must		
•••	also maintain a signature page that		
	designates the full name that corresponds to		
	each initial used to document administered		
	or assisted delivery of each dose; and		
i.	Information from the prescribing pharmacy		
	regarding medications must be kept in the home and community inclusion service		
	locations and must include the expected		
	desired outcomes of administering the		
	medication, signs and symptoms of adverse		
	events and interactions with other		
	medications.		

j. Medication Oversight is optional if the		
individual resides with their biological family		
(by affinity or consanguinity). If Medication		
Oversight is not selected as an Ongoing		
Nursing Service, all elements of medication		
administration and oversight are the sole		
responsibility of the individual and their		
biological family. Therefore, a monthly		
medication administration record (MAR) is		
not required unless the family requests it		
and continually communicates all medication		
changes to the provider agency in a timely		
manner to insure accuracy of the MAR.		
iv. The family must communicate at least		
annually and as needed for significant		
change of condition with the agency nurse		
regarding the current medications and the		
individual's response to medications for		
purpose of accurately completing required		
nursing assessments.		
v. As per the DDSD Medication Assessment		
and Delivery Policy and Procedure, paid		
DSP who are not related by affinity or		
consanguinity to the individual may not		
deliver medications to the individual unless		
they have completed Assisting with		
Medication Delivery (AWMD) training. DSP		
may also be under a delegation relationship		
with a DDW agency nurse or be a Certified		
Medication Aide (CMA). Where CMAs are		
used, the agency is responsible for		
maintaining compliance with New Mexico		
Board of Nursing requirements.		
vi. If the substitute care provider is a surrogate		
(not related by affinity or consanguinity)		
Medication Oversight must be selected and		
provided.		
CHAPTER 12 (SL) 2. Service Requirements L.		
Training and Requirements: 3. Medication		
Delivery: Supported Living Provider Agencies		
must have written policies and procedures		

regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations.		
e. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;		
f. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:		
 i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; 		
ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;		
iii. Initials of the individual administering or assisting with the medication delivery;		
iv. Explanation of any medication error;		
v. Documentation of any allergic reaction or adverse medication effect; and		
vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of		

effectiveness of PRN medication administered.		
g. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and		
h. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications.		
CHAPTER 13 (IMLS) 2. Service Requirements. B. There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.		

E. Medication Delivery: Provider Agencies		
that provide Community Living, Community		
Inclusion or Private Duty Nursing services shall		
have written policies and procedures regarding		
medication(s) delivery and tracking and		
reporting of medication errors in accordance		
with DDSD Medication Assessment and		
Delivery Policy and Procedures, the Board of		
Nursing Rules and Board of Pharmacy		
standards and regulations.		
(2) When required by the DDSD Medication		
Assessment and Delivery Policy, Medication		
Administration Records (MAR) shall be		
maintained and include:		
(a) The name of the individual, a		
transcription of the physician's written or		
licensed health care provider's		
prescription including the brand and		
generic name of the medication,		
diagnosis for which the medication is prescribed;		
(b) Prescribed dosage, frequency and		
method/route of administration, times		
and dates of administration;		
(c) Initials of the individual administering or		
assisting with the medication;		
(d) Explanation of any medication		
irregularity;		
(e) Documentation of any allergic reaction		
or adverse medication effect; and		
(f) For PRN medication, an explanation for		
the use of the PRN medication shall		
include observable signs/symptoms or		
circumstances in which the medication		
is to be used, and documentation of		
effectiveness of PRN medication administered.		
auministereu.		
(3) The Provider Agency shall also maintain a		
signature page that designates the full name		
that corresponds to each initial used to		

document administered or assisted delivery of		
each dose;		
'		
(4) MARs are not required for individuals		
participating in Independent Living who self-		
administer their own medications;		
auminister their own medications,		
(F) Information from the consequential and because		
(5) Information from the prescribing pharmacy		
regarding medications shall be kept in the		
regarding medications of an be kept in the		
home and community inclusion service		
locations and shall include the expected		
desired outcomes of administrating the		
medication, signs and symptoms of adverse		
medication, signs and symptoms of adverse		
events and interactions with other medications;		
,		

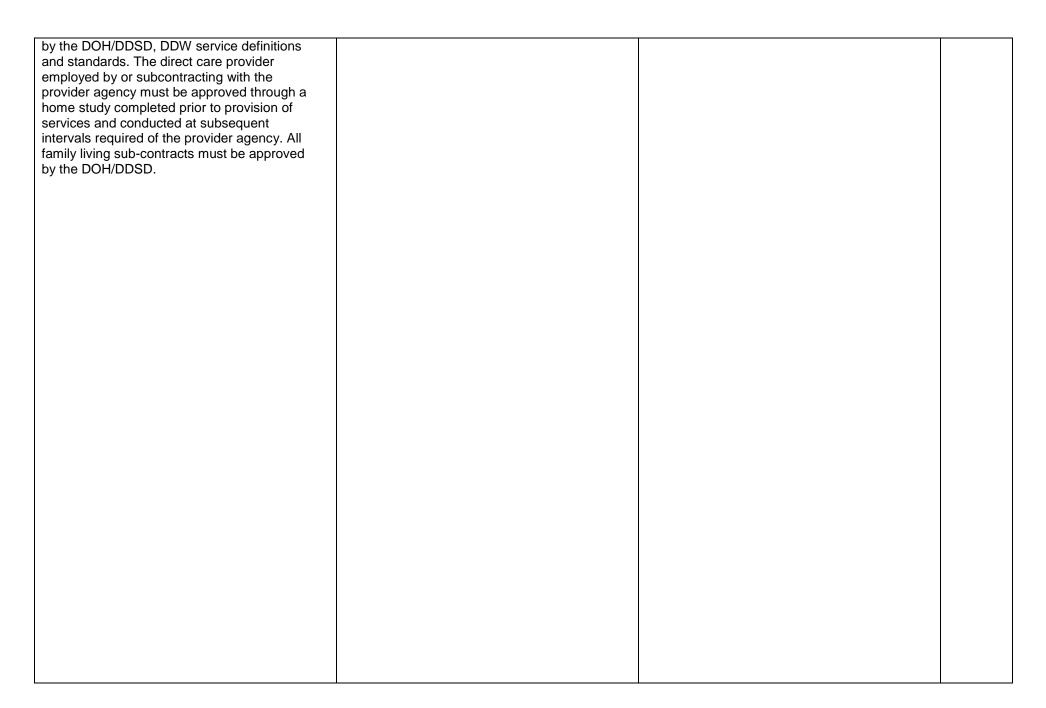
Tag # 1A33	Standard Level Deficiency		
Board of Pharmacy – Med. Storage			
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual E. Medication Storage: 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. 8. References A. Adequate drug references shall be available for facility staff H. Controlled Substances (Perpetual Count Requirement) 1. Separate accountability or proof-of-use	Based on record review and observation, the Agency did not to ensure proper storage of medication for 2 of 11 individuals. Observation included: Individual #2 • Acyclovir: expired 3/2013. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Ranitidine: expired 3/2011. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. • Naproxen: expired 3/2014. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures. Individual #8 • Vitamin D3 2000 IU: expired 2/2015. Expired medications as required by Board of Pharmacy Procedures.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
sheets shall be maintained, for each controlled substance,			
indicating the following information: a. date			

	T	
b. time administered		
c. name of patient		
d. dose		
e. practitioner's name		
e. practitioner s name		
f. signature of person administering or assisting		
f. signature of person administering or assisting with the administration the dose		
g. balance of controlled substance remaining.		
ů		

Tag # LS06 / 6L06	Standard Level Deficiency		
Family Living Requirements			
Developmental Disabilities (DD) Waiver Service	Based on record review, the Agency did not	Provider:	
Standards effective 11/1/2012 revised 4/23/2013	complete all DDSD requirements for approval of each direct support provider for 1 of 7	State your Plan of Correction for the deficiencies cited in this tag here: →	
CHAPTER 12 (FL) I. Living Supports – Family Living Home Studies: The Living Supports-Family Living Services Provider Agency must complete all Developmental Disabilities Support Division (DDSD) requirements for approval of each direct support provider, including completion of an approved home study and training of the direct support provider prior to placement. After the initial home study, an updated home study must be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies must be approved by DDSD. 2. Service Requirements:	individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current: • Family Living (Annual Update) Home Study • Individual #1 - Not Found.	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
E. Supervision: The Living Supports- Family Living Provider Agency must provide and document:			
Monthly face to face consultation, by agency supervisors or internal service coordinators, with the DSP on at least a monthly basis to include:			
a. Review implementation of the individual's ISP Action Plans and associated support plans, including, Positive Behavior Support Plan (PBSP), Written Direct Support Instructions,(WDSI) from therapist(s) serving the individual, schedule of activities and appointments; and advise direct support personnel regarding expectations and next steps including need for individual specific			

training or retraining from therapists and Behavior Support Consultants;		
 Review implementation and the effectiveness of therapy, healthcare, PBSP, Behavior Crisis Intervention Plan (BCIP), MERP, and Comprehensive Aspiration Risk Management Plan (CARMP) plans if applicable; 		
 c. Assist with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator or other IDT members; and 		
d. Monitor the Assistive Technology Inventory to ensure that needed adaptive equipment, augmentative communication and assistive technology devices are available and functioning properly.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES A. Support to Individuals in Family Living: The Family Living Services Provider Agency shall provide and document:		
(5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include:		
 (a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and 		
(b) Assist with service or support issues raised by the direct support provider		

or observed by supervisor, service coordinator or other IDT members.		
B. Home Studies. The Family Living Services Provider Agency shall complete all DDSD requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1. I. PROVIDER AGENCY ENROLLMENT PROCESS D. Scope of DDSD Agreement		
(4) Provider Agencies must have prior written approval of the Department of Health to subcontract any service other than Respite;		
NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY- BASED SERVICES WAIVER		
ELIGIBLE PROVIDERS: I. Qualifications for community living service providers: There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (1) Family living service providers for adults must meet the qualifications for staff required		



Гаg # LS13 / 6L13	Standard Level Deficiency		
Community Living Healthcare Reqts.			
NMAC 8.302.1.17 RECORD KEEPING AND	Based on record review, the Agency did not	Provider:	
DOCUMENTATION REQUIREMENTS: A	provide documentation of annual physical	State your Plan of Correction for the	
rovider must maintain all the records	examinations and/or other examinations as	deficiencies cited in this tag here: →	
ecessary to fully disclose the nature, quality,	specified by a licensed physician for 1 of 7		
mount and medical necessity of services	individuals receiving Community Living Services.		
urnished to an eligible recipient who is			
currently receiving or who has received	Review of the administrative individual case files		
ervices in the past.	revealed the following items were not found,		
·	incomplete, and/or not current:		
B. Documentation of test results: Results of			
ests and services must be documented, which	Involuntary Movement Evaluations		
ncludes results of laboratory and radiology	° None found 4/2014 - 3/2015 for		
procedures or progress following therapy or	Risperidone (#7).		
reatment.	Table (at).		
		Provider:	
Developmental Disabilities (DD) Waiver Service		Enter your ongoing Quality Assurance/Quality	
Standards effective 11/1/2012 revised 4/23/2013		Improvement processes as it related to this tag	
		number here: →	
Chapter 11 (FL) 3. Agency Requirements:			
D. Consumer Records Policy: All Family			
iving Provider Agencies must maintain at the			
Idministrative office a confidential case file for			
ach individual. Provider agency case files for			
ndividuals are required to comply with the			
DDSD Individual Case File Matrix policy.			
The Matrix policy.			
Chapter 12 (SL) 3. Agency Requirements:			
D. Consumer Records Policy: All Living			
Supports- Supported Living Provider Agencies			
nust maintain at the administrative office a			
onfidential case file for each individual.			
rovider agency case files for individuals are			
equired to comply with the DDSD Individual			
Case File Matrix policy.			
Jaco I no Matrix policy.			
Developmental Disabilities (DD) Waiver			
Service Standards effective 4/1/2007			
HAPTER 6. VI. GENERAL			
IIAI ILIVO. VI. ULIILIVAL			
EQUIREMENTS FOR COMMUNITY LIVING			

G. Health Care Requirements for		
Community Living Services.		
(1) The Community Living Service providers		
shall ensure completion of a HAT for each		
individual receiving this service. The HAT shall		
be completed 2 weeks prior to the annual ISP		
meeting and submitted to the Case Manager		
and all other IDT Members. A revised HAT is		
required to also be submitted whenever the		
individual's health status changes significantly.		
For individuals who are newly allocated to the		
DD Waiver program, the HAT may be		
completed within 2 weeks following the initial		
ISP meeting and submitted with any strategies		
and support plans indicated in the ISP, or		
within 72 hours following admission into direct		
services, whichever comes first.		
(2) Each individual will have a Health Care		
Coordinator, designated by the IDT. When the		
individual's HAT score is 4, 5 or 6 the Health		
Care Coordinator shall be an IDT member,		
other than the individual. The Health Care		
Coordinator shall oversee and monitor health		
care services for the individual in accordance		
with these standards. In circumstances where		
no IDT member voluntarily accepts designation		
as the health care coordinator, the community		
living provider shall assign a staff member to		
this role.		
(3) For each individual receiving Community		
Living Services, the provider agency shall		
ensure and document the following:		
(a)Provision of health care oversight		
consistent with these Standards as		
detailed in Chapter One section III E:		
Healthcare Documentation by Nurses For		
Community Living Services, Community		
Inclusion Services and Private Duty		
Nursing Services.		
b) That each individual with a score of 4, 5,		

or 6 on the HAT, has a Health Care Plan

developed by a licensed nurse.

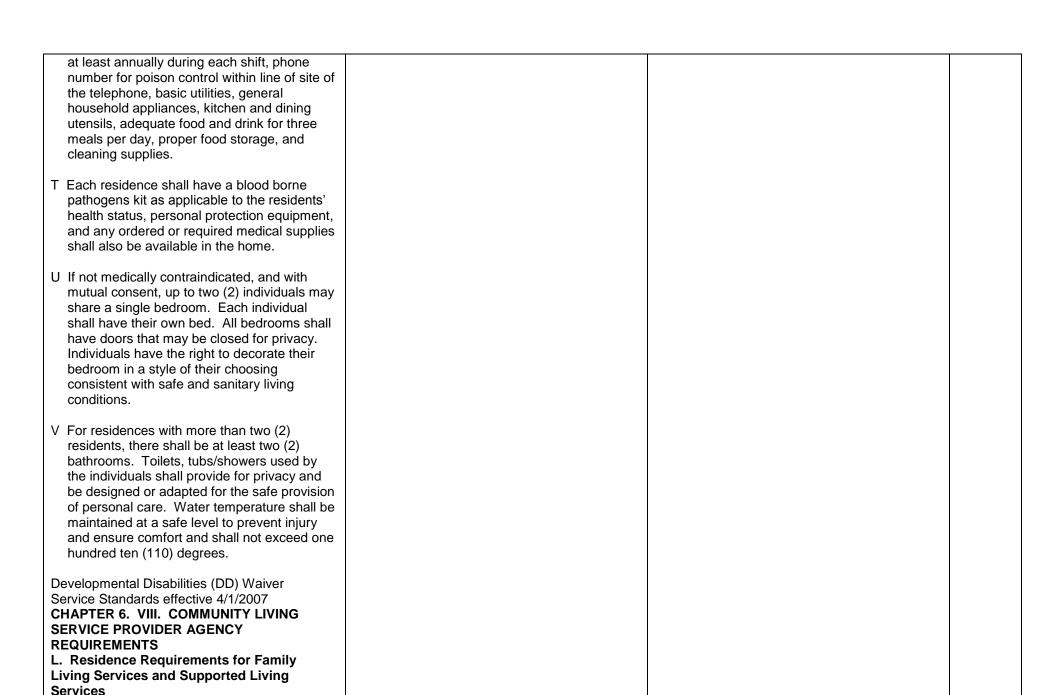
(c)That an individual with chronic		
condition(s) with the potential to		
exacerbate into a life threatening		
condition, has Crisis Prevention/		
Intervention Plan(s) developed by a		
licensed nurse or other appropriate		
professional for each such condition.		
(4) That an average of 3 hours of documented		
nutritional counseling is available annually, if recommended by the IDT.		
(5) That the physical property and grounds are		
free of hazards to the individual's health and		
safety.		
(6) In addition, for each individual receiving		
Supported Living or Family Living Services, the		
provider shall verify and document the		
following:		
(a)The individual has a primary licensed		
physician;		
(b)The individual receives an annual		
physical examination and other		
examinations as specified by a licensed		
physician;		
(c)The individual receives annual dental		
check-ups and other check-ups as		
specified by a licensed dentist;		
(d)The individual receives eye examinations as specified by a licensed optometrist or		
ophthalmologist; and		
(e)Agency activities that occur as follow-up		
to medical appointments (e.g. treatment,		
visits to specialists, changes in		
medication or daily routine).		
,		
]	
]	
	<u> </u>	

Tag # LS25 / 6L25	Standard Level Deficiency		1
Residential Health and Safety (SL/FL)	Standard Level Deliciency		
Developmental Disabilities (DD) Waiver Service	Based on observation, the Agency did not	Provider:	
Standards effective 11/1/2012 revised 4/23/2013	ensure that each individuals' residence met all	State your Plan of Correction for the	
CHAPTER 11 (FL) Living Supports – Family	requirements within the standard for 4 of 7	deficiencies cited in this tag here: →	
Living Agency Requirements G. Residence	Family Living residences.		
Requirements for Living Supports- Family			
Living Services: 1.Family Living Services	Review of the residential records and		
providers must assure that each individual's	observation of the residence revealed the		
residence is maintained to be clean, safe and	following items were not found, not functioning		
comfortable and accommodates the individuals' daily living, social and leisure activities. In	or incomplete:		
addition the residence must:	Family Living Requirements:		
addition the residence mast.	Talling Elving Rodalionion		
j. Maintain basic utilities, i.e., gas, power, water	Battery operated or electric smoke detectors,		
and telephone;	carbon monoxide detectors, fire extinguisher,		
	or a sprinkler system installed in the residence	Provider:	
k. Provide environmental accommodations and	(#1, 8)	Enter your ongoing Quality Assurance/Quality	
assistive technology devices in the residence including modifications to the bathroom (i.e.,	A	Improvement processes as it related to this tag number here: →	
shower chairs, grab bars, walk in shower,	Accessible written procedures for emergency evacuation e.g. fire and weather-related	number nere. →	
raised toilets, etc.) based on the unique	threats (#1, 7)		
needs of the individual in consultation with			
the IDT;	Accessible written procedures for the safe		
	storage of all medications with dispensing		
Have a battery operated or electric smoke	instructions for each individual that are		
detectors, carbon monoxide detectors, fire	consistent with the Assisting with Medication		
extinguisher, or a sprinkler system;	Administration training or each individual's ISP		
m. Have a general-purpose first aid kit;	(#5, 7)		
m. Have a general-purpose first aid kit;	Aggazible written procedures for emergency		
n. Allow at a maximum of two (2) individuals to	Accessible written procedures for emergency placement and relocation of individuals in the		
share, with mutual consent, a bedroom and	event of an emergency evacuation that makes		
each individual has the right to have his or	the residence unsuitable for occupancy. The		
her own bed;	emergency evacuation procedures shall		
	address, but are not limited to, fire, chemical		
o. Have accessible written documentation of	and/or hazardous waste spills, and flooding		
actual evacuation drills occurring at least	(#5, 7)		
three (3) times a year;			
p. 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		
q. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.		
CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services: 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must:		
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. Ensure water temperature in home does not exceed safe temperature (110°F);		
d. Have a battery operated or electric smoke		

fire extinguisher, or a sprinkler system;

e.	Have a general-purpose First Aid kit;		
f.	Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;		
g.	Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift;		
h.	Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and		
i.	Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.		
R Q	HAPTER 13 (IMLS) 2. Service Requirements . Staff Qualifications: 3. Supervisor ualifications And Requirements: Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring		



Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		ists to assure that claims are coded and pa	id for in
Tag # IS30	odology specified in the approved waiver. Standard Level Deficiency		
Customized Community Supports	Otanidara Ecver Denoiciney		
Reimbursement			
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 6 (CCS) 4. REIMBURSEMENT A. Required Records: All Provider Agencies must maintain all records necessary to fully disclose the type, quality, quantity and clinical necessity of services furnished to individuals who are currently receiving services. The Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, nature of services, and length of a session of service billed. 1. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit billed, the record shall contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 1 of 5 individuals. Individual #4 April 2015 • The Agency billed 247 units of Customized Community Supports (Group) (T2021 HB U9) from 4/1/2015 through 4/30/2015. Documentation received accounted for 229 units. Individual #4 May 2015 • The Agency billed 33 units of Customized Community Supports (Individual) (H2021 HB U1) from 5/12/2015 through 5/14/2015. Documentation received accounted for 32 units.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
 providing the service. B. Billable Unit: The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit. 			

The billable unit for Community Inclusion Aide is a fifteen (15) minute unit.		
The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group.		
 The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under Customized Community Supports without prior approval from DDSD. 		
5. The billable unit for Intensive Behavioral Customized Community Supports is a fifteen (15) minute unit. (There is a separate rate established for individuals who require one-to-one (1:1) support either in the community or in a group day setting due to behavioral challenges (NM DDW group G).		
6. The billable unit for Fiscal Management for Adult Education is dollars charged for each class including a 10% administrative processing fee.		
C. Billable Activities: 1. All DSP activities that are:		
a. Provided face to face with the individual;		
b. Described in the individual's approved ISP;		
c. Provided in accordance with the Scope of Services; and		
 d. Activities included in billable services, activities or situations. 		

 Purchase of tuition, fees, and/or related materials associated with adult education opportunities as related to the ISP Action Plan and Outcomes, not to exceed \$550 including administrative processing fee. 		
 Customized Community Supports can be included in ISP and budget with any other services. 		
MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.		

Tag # IH32	Standard Level Deficiency		
Customized In-Home Supports			
Reimbursement			
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 7 (CIHS) 4. REIMBURSEMENT. A. All Provider Agencies must maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the individual's name, date, time, Provider Agency name, nature of services and length of a session of service billed. 4. The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the Human Services Department (HSD). For each unit	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized In-Home Supports Reimbursement for 1 of 4 individuals. Individual #9 May 2015 • The Agency billed 422 units of Customized In-Home Supports (S5125 HB) from 5/1/2015 through 5/22/2015. Documentation received accounted for 386 units.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag	
 billed, the record shall contain the following: a. Date, start and end time of each service encounter or other billable service interval; b. A description of what occurred during the encounter or service interval; and c. The signature or authenticated name of staff 		number here: →	
providing the service. 5. Customized In-Home Supports has two different rates which are based on the individual's living condition (i.e., living with Natural Supports or Living Independently). The maximum allowable billable hours cannot exceed the budget allocation in the associated service packages.			

B.	Billable Units: The billable unit for		
	Customized In-Home Support is based on a		
	fifteen (15) minute unit.		
C.	Billable Activities:		
	Direct care provided to an individual in the individual's residence, consistent with the Scope of Services, any portion of the day.		
	Direct support provided to an individual consistent with the Scope of Services by Customized In-Home Supports direct support personnel in community locations other than the individual's residence.		



Date: December 1, 2015

To: James McDonald, Executive Director Provider: Animas Valley Caring Hands, LLC

Address: P.O. Box 150

State/Zip: Farmington, New Mexico 87499

E-mail Address: avchnm@yahoo.com

Region: Northwest

Survey Date: June 15 - 17, 2015

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Family Living); Inclusion Supports (Customized

Community Supports) and Other (Customized In-Home Supports)

Survey Type: Routine

Dear Mr. McDonald;

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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