Date: May 5, 2016

To: Bill Myers, Senior Director
Provider: Dungarvin New Mexico, LLC.
Address: 2309 Renard Place Suite 205
State/Zip: Albuquerque, New Mexico 87105

E-mail Address: bmyers@dungarvin.com

CC: Dave Toeniskoetter, CEO
E-Mail Address Toeniskoetter@dungarvin.com

Region: Metro
Survey Date: January 25 – 28, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living and Intensive Medical Living Services); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)

Survey Type: Routine

Team Leader: Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Jason Cornwell, MA, MFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Leslie Peterson, MA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Jesus Trujillo, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Myers and Mr. Toeniskoetter,

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

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

Partial Compliance with Conditions of Participation

The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A22 Agency Personnel Competency
- Tag # 1A32 and LS14/6L14 Individual Service Plan Implementation

This determination is based on noncompliance with one or more CMS waiver assurances at the Condition of Participation level as well as Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

Plan of Correction:

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

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

Corrective Action:

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

On-going Quality Assurance/Quality Improvement Processes:

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

Submission of your Plan of Correction:

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

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

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

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

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

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

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check,

please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or if using UPS, FedEx, DHL (courier mail) send to physical address at:

Attention: Julie Ann Hill-Clapp
HSD/OIG
Program Integrity Unit
2025 S. Pacheco Street
Santa Fe, New Mexico 87505

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

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

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

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 total business days (10 business days to submit your 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,

Erica Nilsen, BA

Erica Nilsen, BA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	January 25, 2016	
Present:	**Dungarvin New Mexico, LLC.** Brianne Conner, Director Julie Matthews, Director Bill Myers, Senior Director **DOH/DHI/QMB** Erica Nilsen BA, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Jason Cornwell, MA, MFA, Healthcare Surveyor Leslie Peterson, MA, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor Jesus Trujillo, RN, Healthcare Surveyor	
Exit Conference Date:	January 28, 2016	
Present:	**Dungarvin New Mexico, LLC.** Brianne Conner, Director Julie Matthews, Director Bill Myers, Senior Director Richard Vallez, Program Director Judy Bencomo, Program Director Robert Bachicha, Regional Director (via telephone) **DOH/DHI/QMB** Erica Nilsen BA, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Jason Cornwell, MA, MFA, Healthcare Surveyor Leslie Peterson, MA, Healthcare Surveyor Corrina Strain, RN, BSN, Healthcare Surveyor Jesus Trujillo, RN, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	15 4 - *Jackson* Class Members 11 - Non-*Jackson* Class Members 13 - Supported Living 1 - Intensive Medical Living Services 3 - Adult Habilitation 8 - Customized Community Supports 1 - Customized In-Home Supports
Total Homes Visited	Number:	10
❖ Supported Living Homes Visited	Number:	10

Note: The following Individuals share a SL residence:
- #3, 5
- #8, 12
- #6, 9
- #4, 14 (IMLS)

• Intensive Medical Homes Visited	Number:	1

Note: The following Individuals share an IMLS residence:
- #4 (SL), 14

Persons Served Records Reviewed	Number:	15
Persons Served Interviewed	Number:	13
Persons Served Not Seen and/or Not Available	Number:	2 (2 individuals were not available during on site survey)
Direct Support Personnel Interviewed	Number:	20
Direct Support Personnel Records Reviewed	Number:	101
Service Coordinator Records Reviewed	Number:	3

Administrative Processes and Records Reviewed:

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

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
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
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
    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.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

POC Document Submission Requirements

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

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.

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.

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

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

Service Domain: Level of Care

Condition of Participation:

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

Service Domain: Plan of Care

Condition of Participation:

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

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Plan of Care

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Dungarvin New Mexico, LLC. - Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living and Intensive Medical Living Services); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Monitoring Type: Routine Survey
Survey Date: **January 25 – 28, 2016**

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*			
Tag # 1A08 **Agency Case File**	**Standard Level Deficiency**		
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 required to comply with the DDSD Individual Case File Matrix	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 15 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 (#9) *(No Plan of Correction required as budget is delayed due to Third Party Assessor)* • **ISP Teaching and Support Strategies** ◦ *Individual #4 - TSS not found for the following Action Steps:* ◦ Work/learn Outcome Statement: ➢ "Will improve outward appearance by visiting spa." ◦ *Individual #14 - TSS not found for the following Action Steps:* ◦ Fun Outcome Statement: ➢ "Will research vacations as needed."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

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	➢ "Will go on 4 vacations yearly."		

(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 self-administration 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. 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 Individual Service Plan Implementation	Condition of Participation Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 8 of 15 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #3 • None found regarding: Fun Outcome/Action Step: "Will practice learning a dance" for 9/2015 - 11/2015. Action step is to be completed for 15 minutes 2 times per week. Individual #4 • None found regarding: Live Outcome/Action Step: "Will research different fish to own" for 9/2015 - 11/2015. Action step is to be completed once a week till found. • None found regarding: Live Outcome/Action Step: "Will purchase supplies as needed for fish" for 9/2015 - 11/2015. Action step is to be completed weekly.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	• None found regarding: Live Outcome/Action Step: "Will feed fish and keep aquarium clean" for 9/2015 - 11/2015. Action step is to be completed daily. Individual #7 • According to the Live Outcome; Action Step for "Staff will bring in the supplies and assist in selecting the items needed to complete the craft" 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 9/2015 - 11/2015. Individual #14 • None found regarding: Live Outcome/Action Step: "Will work with staff on what he wants to try" for 9/2015 - 11/2015. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "Will make a new dessert" for 9/2015 - 11/2015. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "Will go out to eat burgers" for 9/2015 - 11/2015. Action step is to be completed 2 times per week. • None found regarding: Live Outcome/Action Step: "Will rate his favorite burger" for 9/2015 - 11/2015. Action step is to be completed 2 times per week. Individual #15 • According to the Live Outcome/Action Step: "Will make a list of ingredients and go shopping" is to be completed 1 time per day, 1 time per week, evidence found indicated it		

	was not being completed at the required frequency as indicated in the ISP for 10/2015 - 11/2015. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #3 • None found regarding: Work/learn Outcome/Action Step: "Will volunteer" for 9/2015 – 11/2015. Action step is to be completed 1 time per week. Individual #4 • None found regarding: Work/learn Outcome/Action Step: "Will go to thrift stores, antiques and garage/yard sales" for 9/2015 – 11/2015. Action step is to be completed 3 times per week. • None found regarding: Work/learn Outcome/Action Step: "Will improve his outward appearance by participating in spa-like activities" for 9/2015 – 11/2015. Action step is to be completed 1 time per month. • None found regarding: Work/learn Outcome/Action Step: "Will visit sister/friends in the community" for 9/2015 – 11/2015. Action step is to be completed 1 time per week. Individual #6 • According to the Work/Learn Outcome; Action Step for "Will choose a reading selection he will use access on tablet" is to be completed 4 times per week, evidence found indicated it was not being completed		

	at the required frequency as indicated in the ISP for 9/2015 - 11/2015. • According to the Work/Learn Outcome; Action Step for "Will choose a reading selection based on his choice to read out loud to staff for 15 minutes" is to be completed 4 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2015 - 11/2015. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • According to the Live Outcome; Action Step for "Will fold and put away laundry" 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 9/2015 - 11/2015. • According to the Fun Outcome; Action Step for "Will choose a restaurant" is to be completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2015. • According to the Fun Outcome; Action Step for "Will eat at restaurant" is to be completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/2015. **Residential Files Reviewed:**		

	Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes: Individual #4 • None found regarding: Live Outcome/Action Step: "Will research different fish to own" for 1/1 – 22, 2016. Action step is to be completed 1 time per week till found. • None found regarding: Live Outcome/Action Step: "will purchase the supplies for his fish" for 1/1 – 22, 2016. Action step is to be completed weekly. • None found regarding: Live Outcome/Action Step: "Will feed his fish and keep his aquarium clean" for 1/1 – 25, 2016. Action step is to be completed daily. • None found regarding: Fun Outcome/Action Step: "Will exercise using his Wii games" for 1/1 – 22, 2016. Action step is to be completed 3 times per week. • None found regarding: Fun Outcome/Action Step: "Will walk/exercise at various outdoor parks and/or indoor community centers or malls (weather permitting)" for 1/1 – 22, 2016. Action step is to be completed 5 times per week. Individual #9 • None found for 1/1 – 22, 2016. Individual #14 • None found regarding: Live Outcome/Action Step: "Will receive work with staff on what		

	he wants to try" for 1/1 – 22, 2016. Action step is to be completed 1 times per week. • None found regarding: Live Outcome/Action Step: "Will have a new desert" for 1/1 – 22, 2016. Action step is to be completed 1 times per week.		

Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements:** **I. Reporting Requirements:** The Community Integrated Employment Agency must submit the following: 1. Semi-annual progress reports to the case manager one hundred ninety (190) calendar days following the date of the annual ISP; a. Written updates to the ISP Work/Learn Action Plan annually or as necessary due to change in work goals to the case manager. These updates do not require an IDT meeting unless changes requiring team	Based on record review, the Agency did not complete written status reports as required for 2 of 11 individuals receiving Inclusion Services. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Customized Community Supports Semi-Annual Reports** • Individual #4 - None found for 9/2014 - 1/2015. *(Term of ISP 3/14/2014 – 3/13/2015) (ISP held on 1/20/2015)* • Individual #14 - None found for 12/2014 - 4/2015 and 6/2015 - 12/2015. *(Term of ISP 6/08/2014 - 6/07/2015 and Term of ISP 6/08/2015 - 6/07/2016) (ISP held on 4/09/2015)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

input need to be made (e.g., adding more hours to the Community Integrated Employment budget); b. Written annual updates to the ISP work/learn action plan to DDSD; 2. VAP to the case manager if completed externally to the ISP; 3. Initial ISP reflecting the Vocational Assessment or the annual ISP with the updated VAP integrated or a copy of an external VAP if one was completed to DDSD; 4. Quarterly Community Integrated Employment Wage and Hour Reports for individuals employed and in job development to DDSD based on the DDSD fiscal year; and a. Data related to the requirements of the Performance Contract to DDSD quarterly. **CHAPTER 6 (CCS) 3. Agency Requirements: H. Reporting Requirements:** The Customized Community Supports Provider Agency shall submit the following: 1. Semi-annual progress reports one hundred ninety (190) days following the date of the annual ISP, and 14 days prior to the annual IDT meeting: a. Identification of and implementation of a Meaningful Day definition for each person served; b. Documentation for each date of service delivery summarizing the following: i. Choice based options offered throughout the day; and			

ii. Progress toward outcomes using age appropriate strategies specified in each individual's action steps in the ISP, and associated support plans/WDSI. c. Record of personally meaningful community inclusion activities; and d. Written updates, to the ISP Work/Learn Action Plan annually or as necessary due to change in work goals. These updates do not require an IDT meeting unless changes requiring team input need to be made. e. Data related to the requirements of the Performance Contract to DDSD quarterly. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS** **E. Provider Agency Reporting Requirements:** All Community Inclusion Provider Agencies are required to submit written quarterly status reports to the individual's Case Manager no later than fourteen (14) calendar days following the end of each quarter. In addition to reporting required by specific Community Access, Supported Employment, and Adult Habilitation Standards, the quarterly reports shall contain the following written documentation: (1) Identification and implementation of a meaningful day definition for each person served; (2) Documentation summarizing the following: (a) Daily choice-based options; and (b) Daily progress toward goals using age-appropriate strategies specified in each individual's action plan in the ISP.			

(3) Significant changes in the individual's routine or staffing; (4) Unusual or significant life events; (5) Quarterly updates on health status, including changes in medication, assistive technology needs and durable medical equipment needs; (6) Record of personally meaningful community inclusion; (7) Success of supports as measured by whether or not the person makes progress toward his or her desired outcomes as identified in the ISP; and (8) Any additional reporting required by DDSD.			

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 12 (SL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 13 (IMLS) 2. Service Requirements** **B.1. Documents To Be Maintained In The Home:** a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access; b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable; d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website; g. Medication Administration Records for the current month; h. Record of medical and dental appointments for the current year, or during the period of stay for	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 8 of 14 Individuals receiving Supported Living Services and Intensive Medical Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ° Did not contain Pharmacy Information (#4, 9, 14, 15) • Annual ISP (#9) • ISP Signature Page (#9) • Addendum A (#9) • Individual Specific Training Section of ISP (formerly Addendum B) (#9) • **ISP Teaching and Support Strategies** ° *Individual #4 - TSS not found for the following Action Steps:* ° Live Outcome Statement: ➢ "Will research different fish to own." ➢ "Will purchase the supplies for his fish." ➢ "Will feed his fish and keep his aquarium clean." ° (Fun) Outcome Statement: ➢ "Will exercise using his Wii games."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced 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:	➢ "Will walk/exercise at various outdoor parks and/or indoor community centers or malls (weather permitting)." ➢ "Will attend and walk through a car show." ◦ *Individual #9 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "Will use IPad to find healthy recipes." ➢ "Will prepare a menu and list of ingredients." ➢ "Will cook a balanced meal." ◦ Fun Outcome Statement: ➢ "Will have informal meetings with a friend." ➢ "Will learn common interests." ➢ "Will plan to meet and write down on calendar." ◦ *Individual #11 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "Will select and purchase an item for his room." ◦ *Individual #14 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "Will receive work with staff on what he wants to try." ➢ "Will have a new dessert."		

(1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery;	➢ "Will be added to cookbook if he likes it." ◦ Fun Outcome Statement: ➢ "Will research possible vacation ideas." ➢ "Will go on 4 mini vacations over the plan year." • Behavior Crisis Intervention Plan (#8, 15) • Speech Therapy Plan (#12) • Physical Therapy Plan (#4, 7) • **Health Care Plans** ◦ Body Mass Index (#15) ◦ High Cholesterol (#15) ◦ PICA (#15)		

(f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.			

Tag # LS17 / 6L17 Reporting Requirements (Community Living Reports)	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 3. Agency Requirements: E. Living Supports- Family Living Service Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Family Living Provider must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports	Based on record review, the Agency did not complete written status reports for 2 of 15 individuals receiving Living Services. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Supported Living Semi-Annual Reports:** • Individual #4 - None found for 9/2014 - 1/2015. *(Term of ISP 3/14/2014 – 3/13/2015) (ISP meeting held on 1/20/2015)* **Intensive Medical Living Services Semi-Annual Reports:** • Individual #14 - None found for 12/2014 - 4/2015 and 6/2015 - 12/2015. *(Term of ISP 6/08/2014 - 6/07/2015 and Term of ISP 6/08/2015 - 6/07/2016) (ISP meeting held on 4/09/2015)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

must contain the following written documentation: a. Name of individual and date on each page; b. Timely completion of relevant activities from ISP Action Plans; c. Progress towards desired outcomes in the ISP accomplished during the past six month; d. Significant changes in routine or staffing; e. Unusual or significant life events, including significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports. **CHAPTER 12 (SL) 3. Agency Requirements: E. Living Supports- Supported Living Service Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Supported Living providers must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation: a. Name of individual and date on each page; b. Timely completion of relevant activities from ISP Action Plans;			

c. Progress towards desired outcomes in the ISP accomplished during the past six (6) months; d. Significant changes in routine or staffing; e. Unusual or significant life events, including significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports. **CHAPTER 13 (IMLS) 3. Agency Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program:** 4. Intensive Medical Living Services providers shall submit a written semi-annual (non-nursing) status report to the individual's case manager and other IDT members no later than the one hundred ninetieth (190th) day following ISP effective date. These semi-annual status reports shall contain at least the following information: a. Status of completion of ISP Action Plans and associated support plans and/or WDSI; b. Progress towards desired outcomes; c. Significant changes in routine or staffing; d. Unusual or significant life events; and e. Data reports as determined by the IDT members;			

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** D. Community Living Service Provider Agency Reporting Requirements: **All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following written documentation:** (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.			

Tag # IH17 Reporting Requirements (Customized In-Home Supports Reports)	Standard Level Deficiency		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 7 (CIHS) 3. Agency Requirements: F. Customized In-Home Supports Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Customized In-Home Supports providers must submit written semi-annual status reports to the individual's Case Manager and other IDT members no later than one hundred ninety (190) calendar days after the ISP effective date and fourteen (14) calendar days prior to the annual ISP meeting. When reports are developed in any language other than English, it is the responsibility of the provider to translate the	Based on record review, the Agency did not complete written status reports for 1 of 1 individuals receiving Customized In-Home Supports. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Customized In-Home Supports Semi-Annual Reports:** • Individual #2 - None found for 7/2014 - 12/2014 – 5/2015. *(Term of ISP 7/10/2014 – 7/9/2015) (ISP meeting held 5/19/2015)*	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

reports into English. The semi-annual reports must contain the following written documentation: a. Name of individual and date on each page; b. Timely completion of relevant activities from ISP Action Plans; c. Progress towards desired outcomes in the ISP accomplished during the past six (6) months; d. Significant changes in routine or staffing; e. Unusual or significant life events, including significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports.			

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-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*			
Tag # 1A20 **Direct Support Personnel Training**	**Standard Level Deficiency**		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 2 of 101 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • First Aid (DSP #237) • CPR (DSP #237) • Rights and Advocacy (DSP #214) • Teaching and Support Strategies (DSP #214)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

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 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 # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 9 of 20 Direct Support Personnel. **When DSP were asked if they received training on the Individual's Individual Service Plan and what the plan covered, the following was reported:** • DSP #287 stated, "Yes." However staff could not identify what the outcomes covered. (Individual #6) **When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:** • DSP #233 stated, "He doesn't need one right now." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #4) **When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:** • DSP #203 stated, "Yes, it covers that he cannot sit in the front seat of car." According to the Individual Specific Training Section of the ISP, the individual does not have a	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and	Behavioral Crisis Intervention Plan. (Individual #12) • DSP #230 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual has a Behavioral Crisis Intervention Plan. (Individual #8) • DSP #233 stated, "No." According to the Individual Specific Training Section of the ISP, the individual has a Behavioral Crisis Intervention Plan. (Individual #4) • DSP #238 stated, "I don't really know about that right now." According to the Individual Specific Training Section of the ISP, the individual has a Behavioral Crisis Intervention Plan. (Individual #6) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #238 stated, "Yes, I haven't been trained." According to the Individual Specific Training Section of the ISP, the Individual does not require a Speech Therapy Plan. (Individual #6) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #227 stated, "No occupational plan. They stopped. She never came anyway." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #14)		

Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.	• DSP #295 stated, "Not at this time." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #8) **When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #238 stated, "Yes, swimming and stuff." According to the Individual Specific Training Section of the ISP, the Individual does <u>not</u> require a Physical Therapy Plan. (Individual #6) **When DSP were asked if the Individual had any specific dietary and/or nutritional requirements and if so, what the plan covered, the following was reported:** • DSP #238 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Nutritional/Dietary Plan. (Individual #6) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #287 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for PRN Psychoactive Medications (Individual #6) **When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:**		

B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;	• DSP #230 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Penicillin and Divalproex Sodium. (Individual #8) • DSP #260 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Haldol and Thorazine. (Individual #15) • DSP #299 stated, "Only when window is open his eyes get watery." As indicated by the Electronic Comprehensive Health Assessment Tool the individual is allergic to Ampicillin, Morphine, and Amoxicillin. (Individual #11)		

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Standard Level Deficiency		
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. 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	Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 1 of 104 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #257 – Date of hire 8/31/2015, completed 9/4/2015.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.			

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer. **C. Incident management system training curriculum requirements:**	Based on record review and interview, the Agency did not ensure Incident Management Training for 5 of 104 Agency Personnel. **When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect and Exploitation, the following was reported:** • DSP #287 stated, "Adult Protective Services." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #227 stated, "The state of New Mexico." Staff was not able to identify the State Agency as Division of Health Improvement. **When DSP were asked to give examples of Exploitation, the following was reported:** • DSP #221 stated, "I don't know." • DSP #260 stated, "Giving his information to my family members or anyone else." • DSP #299 stated, "I'm not too sure."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

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

made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule. **Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*			
Tag #1A08.2 Healthcare Requirements	**Standard Level Deficiency**		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **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.	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 4 of 15 individuals receiving Community Inclusion, Living Services and Other Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Annual Physical** (#2) ***Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):*** • ***Dental Exam*** ◦ Individual 14 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • ***Vision Exam*** ◦ Individual #3 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

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. **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 required to comply with the DDSD Individual Case File Matrix policy. **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	◦ Individual #14 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. • ***Bone Density Exam*** ◦ Individual #7 - As indicated by collateral documentation reviewed, exam was completed on 1/2/2013. Follow-up was to be completed in 2 years. No evidence of follow-up found.		

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)… 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: (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; **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP			

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

Tag # 1A09 Medication Delivery Routine Medication Administration	Standard Level Deficiency		
NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and	Medication Administration Records (MAR) were reviewed for the months of December 2015 and January 2016 Based on record review, 4 of 14 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 December 2015 Medication Administration Record did not contain the specific time(s) the medication should be given, for the following medications: • Ibuprofen 400mg (2 times daily) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Ibuprofen 400mg (2 times daily) – Blank 12/17, 18, 19, 20, 21, 22, 24, 25, 26, 27 Individual #4 January 2016 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Risperidone .5mg (3 times daily) – Blank 1/9, 18 - 24 (8pm) • Risperidone 1mg (3 times daily) – Blank 1/22 (1pm) Individual #14 January 2016	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

➢ 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,	Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Erythromycin Eye Ointment (1 time daily) – Blank 1/22 (1pm) • Finasteride 5mg (1 time daily) – Blank 1/22 (8am) Individual #15 December 2015 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Citrucel 500mg (1 time daily) – Blank 12/31 (8PM)		

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

i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments. ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements. iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided. **CHAPTER 12 (SL) 2. Service Requirements 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. h. 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;			

i. 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. j. 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 k. 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:** **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication,			

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

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Standard Level Deficiency		
NMAC 16.19.11.8 MINIMUM STANDARDS: **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and	Medication Administration Records (MAR) were reviewed for the months of December 2015 and January 2016. Based on record review, 1 of 14 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #7 January 2016 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Hemorrhoidal Topical Pads Medicated 50% – PRN – 1/2, 3, 16 (given 1 time)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

➢ the exact amount to be used in a 24-hour period. **Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006** **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications.			

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

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). 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 individuals must be licensed by the Board of Pharmacy, per current regulations; g. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. h. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and 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. l. 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; m. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error;			

v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. n. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and o. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of 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. (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 # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Standard Level Deficiency		
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. **Chapter 6 (CCS) 2. Service Requirements. E.** The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service; **3. Agency Requirements: 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 required to comply with the DDSD Individual Case File Matrix policy. **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.	Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 15 individuals Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • **Quarterly Nursing Review of HCP/Medical Emergency Response Plans:** ◦ None found for 1/2015 – 6/2015 (#7)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

I. Health Care Requirements for Family Living: 5. A nurse employed or contracted by the Family Living Supports provider must complete the e-CHAT, the Aspiration Risk Screening Tool, (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration. a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first. b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting. c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization. **d.** Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual			

complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **e.** Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice. **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. **2. Service Requirements. L. Training and Requirements. 5. Health Related Documentation:** For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following: a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s),			

and ensure that a copy of such plan(s) are readily available to DSP in the home; b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated; c. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and d. Document for each individual that: i. The individual has a Primary Care Provider (PCP); ii. The individual receives an annual physical examination and other examinations as specified by a PCP; iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; iv. The individual receives a hearing test as specified by a licensed audiologist; v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).			

vii. The agency nurse will provide the individual's team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually. **f.** The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards. **Chapter 13 (IMLS) 2. Service Requirements:** C. Documents to be maintained in the agency administrative office, include: A. All assessments completed by the agency nurse, including the Intensive Medical Living Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall suffice; F. Annual physical exams and annual dental exams (not applicable for short term stays); G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for allowable exceptions for more frequent vision exam); H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements); I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange; J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay);			

L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay); O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays); P. Quarterly nursing summary reports (not applicable for short term stays); **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.			

3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located. 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, 2, 3, 4, 5, 6, 7, 8, **CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment**			

activities (2) Health related plans and (4) General Nursing Documentation Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination** (2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.			

Tag # 1A31 Client Rights/Human Rights	Standard Level Deficiency		
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division**	Based on record review, the Agency did not ensure the rights of Individuals were not restricted or limited for 1 of 15 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • Psychotropic Medications to control behaviors. No evidence found of Human Rights Committee approval. (Individual #8)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003 **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least			

five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery** **Procedure Eff Date: November 1, 2006** **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).			

Tag # 1A33 Board of Pharmacy – Med. Storage	Standard Level Deficiency		
New Mexico Board of Pharmacy Model Custodial Drug Procedures Manual **E. Medication Storage:** 1. Prescription drugs will be stored in a locked cabinet and the key will be in the care of the administrator or designee. 2. Drugs to be taken by mouth will be separate from all other dosage forms. 3. A locked compartment will be available in the refrigerator for those items labeled "Keep in Refrigerator." The temperature will be kept in the 36°F - 46°F range. An accurate thermometer will be kept in the refrigerator to verify temperature. 4. Separate compartments are required for each resident's medication. 5. All medication will be stored according to their individual requirement or in the absence of temperature and humidity requirements, controlled room temperature (68-77°F) and protected from light. Storage requirements are in effect 24 hours a day. 6. Medication no longer in use, unwanted, outdated, or adulterated will be placed in a quarantine area in the locked medication cabinet and held for destruction by the consultant pharmacist. **8. References** A. Adequate drug references shall be available for facility staff **H. Controlled Substances (Perpetual Count Requirement)** 1. Separate accountability or proof-of-use sheets shall be maintained, for each controlled substance,	Based on record review and observation, the Agency did not to ensure proper storage of medication for 1 of 14 individuals. Observation included: Individual #10 Wal-Tussin DM: expired 12/2015. Expired medication was not kept separate from other medications as required by Board of Pharmacy Procedures.	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

indicating the following information: a. date b. time administered c. name of patient d. dose e. practitioner's name f. signature of person administering or assisting with the administration the dose g. balance of controlled substance remaining.			

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit; e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 10 of 10 Supported Living and Intensive Medical Living Services residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#15) • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 124.6^0 F (#1) ➢ Water temperature in home measured 113.1^0 F (#3, 5) ➢ Water temperature in home measured 113.6^0 F (#7, 10) ➢ Water temperature in home measured 116.1^0 F (#15) ➢ Water temperature in home measured 116.4^0 F (#6, 9) ➢ Water temperature in home measured 119.1^0 F (#8, 12)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

consistent with the Assisting with Medication Delivery training or each individual's ISP; and h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports-Supported Living Services:** 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition, the residence must: f. Maintain basic utilities, i.e., gas, power, water, and telephone; g. 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; h. Ensure water temperature in home does not exceed safe temperature (110^0 F); i. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system; j. Have a general-purpose First Aid kit; k. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and	➢ Water temperature in home measured 119.6^0 F (#13) ➢ Water temperature in home measured 128.1F (#11) • General-purpose first aid kit (#4, 10) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 3, 4, 5, 11) *Note: The following Individuals share a residence:* ➢ #3, 5, ➢ #8, 12 ➢ #6, 9 ➢ #4, 14 **Intensive Medical Living Services Requirements:** • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#4, 14) • General-purpose first aid kit (#4, 14)		

each individual has the right to have his or her own bed; l. 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; m. 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 n. 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 13 (IMLS) 2. Service Requirements R. Staff Qualifications: 3. Supervisor Qualifications and Requirements:** S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies.	*Note: The following Individuals share a residence:* ➢ #4, 14		

T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home. U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions. V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services**			

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*			
Tag # IS30 **Customized Community Supports Reimbursement**	**Standard Level Deficiency**		
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 providing the service. B. **Billable Unit:**	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 8 individuals. Individual #3 September 2015 • The Agency billed 76 units of Customized Community Supports (Individual) (H2021 HB U1) from 9/13/2015 through 9/19/2015. Documentation received accounted for 48 units. (*Note: No Plan of Correction required, agency provided void and adjust during the on-site survey.)*		

1. The billable unit for Individual Customized Community Supports is a fifteen (15) minute unit. 2. The billable unit for Community Inclusion Aide is a fifteen (15) minute unit. 3. The billable unit for Group Customized Community Supports is a fifteen (15) minute unit, with the rate category based on the NM DDW group. 4. The time at home is intermittent or brief; e.g. one hour time period for lunch and/or change of clothes. The Provider Agency may bill for providing this support under 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. 2. 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. 3. 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.			

Date: July 22, 2016

To: Bill Myers, Senior Director
Provider: Dungarvin New Mexico, LLC.
Address: 2309 Renard Place Suite 205
State/Zip: Albuquerque, New Mexico 87105

E-mail Address: bmyers@dungarvin.com

CC: Dave Toeniskoetter, CEO
E-Mail Address Toeniskoetter@dungarvin.com

Region: Metro
Survey Date: January 25 – 28, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living and Intensive Medical Living Services); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)

Survey Type: Routine

Dear Mr. Myers and Mr. Toeniskoetter,

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.16.3.DDW.D1696.5.RTN.09.16.204