Date:	June 1, 2015
To:	LeShelle Harvey, Assistant Director
Provider: Address: State/Zip:	Expressions Unlimited, Co. 955 San Pedro NE Albuquerque, New Mexico 87108
E-mail Address:	Luvshell22@gmail.com Chrishen1390@gmail.com Thelmah1377@gmail.com
CC: Address: State/Zip:	Jessie Waddles, Board Member 11912 Leah Court Albuquerque, New Mexico 87221
Board Chair Address: State/Zip:	Bill Dorn, Board Member 7611 Rio Penasco NW Albuquerque, New Mexico 87120
Region: Survey Date: Program Surveyed:	Metro March 2 - 4, 2015 Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living) *Inclusion Supports* (Customized Community Supports) ***2007:*** *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type:	Routine
Team Leader:	Florence G. Mulheron, BCJ, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau; Russell Cain, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Erica Neilson, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Jesus Trujillo, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau.

Dear Ms. Harvey;

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:

Non-Compliance with all Conditions of Participation
The following tags are identified as Condition of Participation Level Deficiencies:

- Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry
- Tag # 1A37 Individual Specific Training
- Tag # 1A09 Medication Delivery Routine Medication Administration
- Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation
- Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training
- Tag # LS13 / 6L13 Community Living Healthcare Requirements
- Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)

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

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

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

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

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

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

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

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

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

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

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

Please call the Plan of Correction Coordinator Anthony Fragua at 505-231-7436 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,

Florence G. Mulheron, BCJ

Florence G. Mulheron, BCJ
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	March 2, 2015	
Present:	**<u>Expressions Unlimited, Co.</u>** LaShelle Harvey, Assistant Director Thelma Hilliard, Service Coordinator **<u>DOH/DHI/QMB</u>** Florence G. Mulheron, BCJ, Team Lead/Healthcare Surveyor Russell R. Cain, BSW, Health Care Surveyor Jesus Trujillo, RN, Health Care Surveyor Erica Nilsen, BA, Health Care Surveyor	
Exit Conference Date:	March 4, 2015	
Present:	**<u>Expressions Unlimited, Co.</u>** Chris Henderson, Director LaShelle Harvey, Assistant Director Thelma Hillard, Service Coordinator Tiya Davis, Residential Lead Charlaquice Kipchaba, Direct Support Staff **<u>DOH/DHI/QMB</u>** Florence G. Mulheron, BCJ, Team Lead/Healthcare Surveyor Tony Fragua, BFA, Plan of Correction Coordinator/Program Manager Russell R. Cain, BSW, Health Care Surveyor Jesus Trujillo, RN, Health Care Surveyor Erica Nilsen, BA, Health Care Surveyor **<u>DDSD – Metro Regional Office</u>** Kathleen Linnehan, Regional Manager	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	9 2 - *Jackson* Class Members 7 - Non-*Jackson* Class Members 7 - Supported Living 2 - Adult Habilitation 6 - Customized Community Supports
Total Homes Visited	Number:	5
❖ Supported Living Homes Visited	Number:	5 *Note: The following Individuals share a SL residence:* ➢ #1, 2 ➢ #5, 6
Persons Served Records Reviewed	Number:	9
Persons Served Interviewed	Number:	6

Persons Served Observed	Number:	3 (One Individual refused to participate; one Individual was not available during on-site visit and one Individual was observed during activities)
Direct Support Personnel Interviewed	Number:	9
Direct Support Personnel Records Reviewed	Number:	23
Service Coordinator Records Reviewed	Number:	1

Administrative Processes and Records Reviewed:

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

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division

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 505-231-7436 or email at Anthony.Fragua@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.
6. The POC must be signed and dated by the agency director or other authorized official.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Anthony Fragua at 505-231-7436 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Anthony Fragua, POC Coordinator in any of the following ways:
    a. Electronically at Anthony.Fragua@state.nm.us *(preferred method)*
    b. Fax to 505-222-8661, or
    c. Mail to POC Coordinator, 5301 Central Avenue NE, Suite 400, Albuquerque, NM 87108
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been “approved” or “denied.”

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

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

POC Document Submission Requirements

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

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

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

Attachment B

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

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

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

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

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

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

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

Conditions of Participation (CoPs)

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

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

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: **Expressions Unlimited, Co. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports)
2007: *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Monitoring Type: Routine Survey
Survey Date: **March 2 - 4, 2015**

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	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 8 of 9 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ° None Found (#2, 3, 4, 5, 6, 9) ° Did not contain Pharmacy Information (#7) ° Did not contain Physician's Phone Number (#7) • **ISP budget forms MAD 046** ° Not Found (#2, 3, 6, 8, 9) • **Annual ISP** ° Not Found (#8) ° Not Current (#4, 6, 9) • ISP Signature Page (#3, 4, 8, 9)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD. **Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 13 (IMLS) 2. Service Requirements:** C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items) • Emergency contact information; • Personal identification; • ISP budget forms and budget prior authorization;	• Individual Specific Training Section of ISP (#4, 6, 8, 9) • **ISP Teaching and Support Strategies** ° *Individual #4 - TSS not found for the following Action Steps:* ° Work/Education/Volunteer Outcome Statement ➢ "… will exercise cycles on the stair master completing 400 cycles in the 30 minute period once each day 5 days each week." ° Relationship/Have Fun Outcome Statement ➢ "… will create 7 homemade invitations to her party." ° *Individual #5 - TSS not found for the following Action Steps:* ° Live Outcome Statement ➢ "…will cook meal." ° Work/Education/Volunteer Outcome Statement ➢ "… will make lunch." ° *Individual #9 - TSS not found for the following Action Steps:* ° Work/Education/Volunteer Outcome Statement ➢ "Identify applications for use." ➢ "Using tablet correctly (finger, not hand)." ➢ "Follow Directions." • Positive Behavioral Support Plan (#5, 6) • Behavior Crisis Intervention Plan (#5) • Speech Therapy Plan (#3)		

• ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI); • Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay; • Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; • Written consent by relevant health decision maker and primary care practitioner for 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.	• Occupational Therapy Plan (#5) • Documentation of Guardianship/Power of Attorney (#3, 4, 9) • **Annual Physical** (#4) • **Dental Exam** ◦ Individual #3 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #4 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #4 - 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 #4 - As indicated by collateral documentation reviewed, the exam was completed on 10/23/2014. No evidence of exam results was found.		

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 # 1A08.1 **Agency Case File - Progress Notes**	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements: 6. Reimbursement A. 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 6 (CCS) 3. Agency Requirements: 4. Reimbursement A. Record Requirements 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 7 (CIHS) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 11 (FL) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 12 (SL) 3. Agency Requirements: 2. Reimbursement A. 1.** Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 13 (IMLS) 3. Agency Requirements: 4. Reimbursement A. 1.**…Provider Agencies	Based on record review, the Agency did not maintain progress notes and other service delivery documentation for 7 of 9 Individuals. Review of the Agency individual case files revealed the following items were not found: **Supported Living Progress Notes/Daily Contact Logs** • Individual #1 - None found for 1/9, 13, 30, 2015. • Individual #7 - None found for 12/1 – 2, 2014. • Individual #8 - None found for 1/1 – 19 and 1/27 - 31. • Individual #9 - None found for 1/1 – 19 and 1/27 - 31. **Customized Community Services Notes/Daily Contact Logs** • Individual #2 - None found for 1/28 – 29. • Individual #9 - None found for 11/1/2014 - 1/31/2015. **Adult Habilitation Progress Notes/Daily Contact Logs** • Individual #3 - None found for 11/2, 24, 2014 and 1/1/2015. • Individual #6 - None found for 1/1 – 31, 2015.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… **Chapter 15 (ANS) 4. Reimbursement A. 1.** …Provider Agencies must maintain all records necessary to fully disclose the service, quality…The documentation of the billable time spent with an individual shall be kept on the written or electronic record… 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: (3) Progress notes and other service delivery documentation;			

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 play with full participation in their communities.	After an analysis of the evidence it has been determined the following finding 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 9 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 #1 • None found regarding: Live Outcome/Action Step: "… will call and schedule four Dr. appointments in ISP Year and write the appointment on a calendar" for 2/2014 - 2/2015. • None found regarding: Live: "… will save money plan for and attend the game" for 11/2014 - 2/2015. Individual #2 • None found regarding: Live Outcome/Action Step: "… Will identify what cleaning and organizing products he needs for cleaning and organizing his personal space" for 9/2014 - 1/2015.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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 spend one hour in the day per week working on his personal space with staff support" for 9/2014 - 1/2015. • None found regarding: Health/ Other Outcome/Action Step: "… will allocate funds and purchase his monthly hygiene products" for 9/2014 - 1/2015. • None found regarding: Health/ Other Outcome/Action Step: "… will complete his personal hygiene with little or no prompting daily; taking time to be successful, Daily" for 9/2014 - 1/2015. Individual #7 • None found regarding: Live Outcome/Action Step: "… will research how to organize by looking through magazines" for 11/2014 - 1/2015. • None found regarding: Live Outcome/Action Step: "… will use storage bins/show organizer/shelves to organize her room. Jessica will purchase curtains/furnishings for her room" for 11/2014 - 1/2015. • None found regarding: Live Outcome/Action Step: "… will hang her art work that she made at day program on her bedroom walls" for 11/2014 - 1/2015. • None found regarding: Relationship/Have Fun Outcome/Action Step: "… will research various vacation spots and choose a location" for 11/2014 - 1/2015. • None found regarding: Relationship/Have Fun Outcome/Action Step: "after choosing her ideal vacation she will budget her funds" for 11/2014 - 1/2015.		

	Individual #8 • None found regarding: Live Outcome/Action Step: "… will develop a worm farm" for 11/2014 - 1/2015. Individual #9 • None found regarding: Live Outcome/Action Step: "Learn names of individuals" for 1/2015. • None found regarding: Live Outcome/Action Step: "Learn to make eye contact when talking" for 1/2015. • None found regarding: Live Outcome/Action Step: "Greet a familiar individual with minimal prompting" for 1/2015. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Work/Education/Volunteer Outcome/Action Step: ""… will attend community outings of his choice" for 11/2014 - 1/2015. Individual #2 • None found regarding: Relationship/Have Fun Outcome/Action Step: ""… will exhibit appropriate social interaction with others while attending day programming 80% of the day with little or no prompting" for 9/2014 - 1/2015. • None found regarding: Relationship/Have Fun Outcome/Action Step: ""… will develop a list of strategies to use when times are stressful and/or socially appropriate		

	behavior require prompting” for 9/2014 - 1/2015. Individual #3 • No Outcomes or DDSD exemption/decision justification found for Customized Community Supports Services. As indicated by NMAC 7.26.5.14 “Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver.” Individual #5 • None found regarding: Relationship/Have Fun Outcome/Action Step: “… will attend chorus practice” for 1/2015. Individual #8 • None found regarding: Work/Education/Volunteer Outcome/Action Step: “… will have 12 new places to go to in Albuquerque” for 11/2014 - 1/2015. Individual #9 • None found regarding: Work/Education/Volunteer Outcome/Action Step: “Identify application for use” for 11/2014 - 1/2015. • None found regarding: Work/Education/Volunteer Outcome/Action Step: “using tablet correctly (finger, not hand)” for 11/2014 - 1/2015. • None found regarding: Work/Education/Volunteer Outcome/Action Step: “Follow directions” for 11/2014 - 1/2015. • None found regarding: Relationships/Have Fun Outcome/Action Step: “Identify activities” for 11/2014 - 1/2015.		

	• None found regarding: Relationships/Have Fun Outcome/Action Step: “attend activities” for 11/2014 - 1/2015. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • According to the Work/Education/Learn Outcome; Action Step for “…will choose an activity” is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2014 - 1/2015. • According to the Work/Education/Learn Outcome; Action Step for “… will participate in chosen activity” is to be completed 3 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2014 - 1/2015. Individual #6 • None found regarding: Work/Education/Volunteer Outcome/Action Step: “… will choose beads, colors and create projects to possible sell” for 11/2014 - 1/2015. • None found regarding: Relationship/Have Fun Outcome/Action Step: “He will choose a team for S.O. and practice twice a month” for 11/2014 - 1/2015.		

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 input need to be made (e.g., adding more hours to the Community Integrated Employment); b. Written annual updates to the ISP work/learn action plan to DDSD;	Based on record review, the Agency did not complete written status reports as required for 3 of 8 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 #2 - None found for 2/2014 - 7/2014 and 8/2014 – 1/2015 *(Term of ISP 8/2014 – 7/2015).* • Individual #4 - None found for 5/2014, 7/2014, and 12/2014. *(Term of ISP 12/2013 – 12/2014). Note: Agency completes monthly reports in lieu of semiannual reports.* • Individual #5 - None found for 10/2013 - 4/2014 and 5/2014 – 10/2014. *(Term of ISP 10/2013 – 10/2014).*	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 7 Individuals receiving Supported 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** ° None Found (#5, 7, 9) ° Did not contain the individual's current address (#8) ° Did not contain the individual's phone number (#8) ° Did not contain names and phone numbers of relatives, or guardian or conservator (#1, 2) ° Did not contain Physician's name and phone number Information (#2) ° Did not contain Pharmacy name and phone number (#1, 6) ° Did not contain the individual's Health Plan (insurance, Medicaid, Medicare, etc.) Information (#2) • **Annual ISP** (#6) • Individual Specific Training Section of ISP (formerly Addendum B) (#6) • **ISP Teaching and Support Strategies**	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced 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	° *Individual #1 - TSS not found for the following Action Steps:* ° Live Outcome Statement ➢ "… will access his job web portal and print out his check stubs." ➢ "… will prepare and mail the check stub to SSI." ° *Individual #2 - TSS not found for the following Action Steps:* ° Health Outcome Statement ➢ "Allocate funds and purchase his monthly personal hygiene products." ➢ "will complete personal hygiene with little to no prompting." ° Individual #5 - *TSS not found for the following Action Steps:* ° Live Outcome Statement ➢ "will plan meal." ➢ "will cook meal." ° *Individual #8 - TSS not found for the following Action Steps:* ° Live Outcome Statement ➢ "Shopping for materials." ➢ "… will maintain worm farm." ° Relationship Have Fun Outcome Statement ➢ "Research place." ➢ "Takes Trip." ➢ "Makes Trip photo album." ° Individual #9 - *TSS not found for the following Action Steps:*		

agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed;	◦ Work/Education/Volunteer Outcome Statement ➢ "Identify applications for use." ➢ "Using tablet correctly (finger, not hand)." ➢ "Follow Directions." • Positive Behavioral Plan (#7) • Speech Therapy Plan (#6, 9) • Occupational Therapy Plan (#5) • Healthcare Passport (#5, 6, 9) • **Special Health Care Needs** ◦ Nutritional Plan (#2, 7) • **Health Care Plans** ◦ Oral Hygiene (#5, 6) • **Medical Emergency Response Plans** ◦ Diabetes (#8) ◦ Falls (5) ◦ Glucose Monitoring (#9) ◦ Insulin Administration (#9) ◦ Prater Willis Syndrome (#8) ◦ Respiratory/Asthma (#5, 6, 9) ◦ Seizures/Neuro Device (#5, 6, 9)		

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

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 must contain the following written documentation:	Based on record review, the Agency did not complete written status reports for 3 of 7 individuals receiving Supported 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 #1 - None found for 8/2014 - 2/2015. *(Term of ISP 2/2014 – 2/2015).* • Individual #2 - None found for 11/2014 - 1/2015. *(Term of ISP 8/2014 – 7/2015).* • Individual #8 - None found for 8/2014 - 1/2015. *(Term of ISP 8/2014 – 8/2015).*	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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.			

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 # 1A11.1 Transportation Training	**Standard Level Deficiency**		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy **Eff. Date:** March 1, 2007 **II. POLICY STATEMENTS:** 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 services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) **NMAC 7.9.2 F. TRANSPORTATION:** **(1)** Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training program in passenger transportation assistance	Based on record review and interview, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 15 of 23 Direct Support Personnel. **No documented evidence was found of the following required training:** • Transportation (DSP #200, 201, 202, 203, 207, 208, 209, 210, 212, 213, 217, 221) **When DSP were asked if they had received transportation training including training on the agency's policies and procedures following was reported:** • DSP #204 stated, "No." • DSP #215 stated, "None." • DSP #217 stated, "At different company Bright Horizons was told this would be ok." • DSP #218 stated, "Not through this company."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

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

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

Tag # 1A20 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 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	Based on record review, the Agency did not ensure Orientation and Training requirements were met for 18 of 23 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #201, 202, 209, 212, 218, 220, 221) • Foundation for Health and Wellness (DSP #201, 202, 209, 212, 220) • Person-Centered Planning (1-Day) (DSP #200, 209, 218, 219, 220, 221) • First Aid (DSP #200, 203, 204, 205, 206, 207, 209, 210, 213, 215, 217, 219) • CPR (DSP #200, 203, 204, 205, 206, 207, 209, 210, 213, 215, 217, 219) • Assisting With Medication Delivery (DSP #203, 220, 221) • Participatory Communication and Choice Making (DSP #209, 210, 218, 220) • Rights and Advocacy (DSP #209, 220) • Positive Behavior Supports Strategies (DSP #209, 218, 219, 220, 221) • Teaching and Support Strategies (DSP #209, 218, 219, 220)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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 status to the DDSD Statewide Training Database as specified in the DDSD Policy T-	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 8 of 9 Direct Support Personnel. **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:** • DSP #208 stated, "Was not aware." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #8) • DSP #214 stated, "No, I don't see one." According to the Individual Specific Training Section of the ISP agency file, the individual has Positive Behavioral Crisis Plan. (Individual #4) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #218 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #5) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #214 stated, "None." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the	Health Care Plans for: Body Mass Index and Diabetes. (Individual #4) • DSP #214 stated, "Aspiration, pain, hemorrhoids and bed sores." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for: Seizure, Glucose Monitoring, Insulin Administration, Constipation, Respiration, Falls and Skin and Wound. (Individual #9) • DSP #217 stated, "Aspiration, food soft, seizure, spastic quadriparesis." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for: Bowel and Bladder, Constipation, Falls, Skin and Wound. (Individual #3) • DSP #218 stated, "Seizure, nutritional meal, constipation, Body Mass Index, change in Health Status, Foot Care, Hearing and Medication Administration". As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for: Respiratory. (Individual #6) **When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #208 stated, "Falls, chokes, bad accident." As indicated by the Individual Specific Training section of the ISP, the Individual requires Medical Emergency Response Plans for: Diabetes and Prater Willis Syndrome. (Individual #8)		

Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information	• DSP #210 stated, "Not found in book." As indicated by Individual Specific Training section of the ISP, the Individual requires Medical Emergency Response Plans for: Diabetes and Prater Willis Syndrome. (Individual #8) • DSP #214 stated, "None." As indicated by the Individual Specific Training section of the ISP, the Individual requires Medical Emergency Response Plans for: Diabetes. (Individual #4) • DSP #214 stated, "Medication Administration, Aspiration, MTP, seizure." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Constipation, Falls and Respiratory. (Individual #9) • DSP #218 stated, "Seizure." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Respiratory. (Individual #6) • DSP #220 stated, "Seizure." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Respiratory. (Individual #6) **When DSP were asked if the Individual had a Medical Emergency Response Plan for Seizures and if they had received training on the Individual's Seizure Disorder, the following was reported:** • DSP #215 stated, "Yes" but was not able to elaborate what the Seizure plan requires. As indicated by the Individual Specific Training		

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;	section of the ISP indicates the Individual requires Medical Emergency Response Plans for: Seizures (Individual #2) • DSP #204 stated, "No training with Expressions." As indicated by the Individual Specific Training section of the ISP indicates the Individual requires Medical Emergency Response Plans for: Seizures and the Agency Nurse is responsible for training. (Individual #7) **When DSP were asked if they assisted the individual with medications and had received the Assisting with Medications (AWM) training, the following was reported:** • DSP #210 stated, "Yes." When asked to state the purpose of each medication DSP was unable to give the purpose of Clonazepam. (Individual #8) **When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:** • DSP #210 stated, "Go to med, pop out, documentation, call supervisor, document in progress notes, give reason why and the time." According to DDSD Policy Number M-001 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. (Individual #8)		

	When DSP were asked if they had received training on the Individual's Diabetes, the following was reported: • DSP #214 stated, "No, she doesn't have but read the diagnosis as having diabetes." As indicated by the Individual Specific Training section of the ISP (Residential and Day) DSP are required to receive training on Diabetes within 30 days of working with the Individual. (Individual #4) • DSP #208 stated, "No Training." As indicated by the Individual Specific Training section of the ISP (Residential and Day) staff are required to receive training on Diabetes prior to working alone with the Individual. (Individual #8) **When DSP were asked what medications does the individual take to control Diabetes, the following was reported:** • DSP #210 stated, "Don't know what it is." Per MAR the Individual is prescribed Metformin HCL 500mg 2 times daily. (Individual #8) **When DSP were asked, what medications are prescribed for the individual and to identify the purpose of each medication prescribed for the individual:** • DSP #215 stated, "The medication doesn't have a purpose." Review of MAR had 10 medications listed all containing purpose of medication except Levetiracetan ER 750mg. (Individual #1) • DSP #220 could not identify the purpose of Lexapro and Folic Acid. Review of the MAR did not indicate the purpose of medication. (Individual #5)		

	• DSP #220 could not identify the purpose of Fish Oil. Per MAR no purpose was identified. (Individual #6)		

Tag # 1A25 Criminal Caregiver History Screening	Standard Level Deficiency		
NMAC 7.1.9.8 CAREGIVER AND HOSPITAL CAREGIVER EMPLOYMENT REQUIREMENTS: **F. Timely Submission:** Care providers shall submit all fees and pertinent application information for all individuals who meet the definition of an applicant, caregiver or hospital caregiver as described in Subsections B, D and K of 7.1.9.7 NMAC, no later than twenty (20) calendar days from the first day of employment or effective date of a contractual relationship with the care provider. **NMAC 7.1.9.9 CAREGIVERS OR HOSPITAL CAREGIVERS AND APPLICANTS WITH DISQUALIFYING CONVICTIONS:** **A. Prohibition on Employment:** A care provider shall not hire or continue the employment or contractual services of any applicant, caregiver or hospital caregiver for whom the care provider has received notice of a disqualifying conviction, except as provided in Subsection B of this section. **(1)** In cases where the criminal history record lists an arrest for a crime that would constitute a disqualifying conviction and no final disposition is listed for the arrest, the department will attempt to notify the applicant, caregiver or hospital caregiver and request information from the applicant, caregiver or hospital caregiver within timelines set forth in the department's notice regarding the final disposition of the arrest. Information requested by the department may be evidence, for example, a certified copy of an acquittal, dismissal or conviction of a lesser included crime. **(2)** An applicant's, caregiver's or hospital caregiver's failure to respond within the required timelines regarding the final disposition of the arrest for a crime that would constitute a	Based on record review, the Agency did not maintain documentation indicating no "disqualifying convictions" or documentation of the timely submission of pertinent application information to the Caregiver Criminal History Screening Program was on file for 3 of 24 Agency Personnel. **The following Agency Personnel Files contained no evidence of Caregiver Criminal History Screenings:** **Direct Support Personnel (DSP):** • #209 – Date of hire not provided by the agency. • #211 – Date of hire 8/29/2013. • #222 – Date of hire 2/4/2015.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

disqualifying conviction shall result in the applicant's, caregiver's or hospital caregiver's temporary disqualification from employment as a caregiver or hospital caregiver pending written documentation submitted to the department evidencing the final disposition of the arrest. Information submitted to the department may be evidence, for example, of the certified copy of an acquittal, dismissal or conviction of a lesser included crime. In instances where the applicant, caregiver or hospital caregiver has failed to respond within the required timelines the department shall provide notice by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A., of Section 7.1.9.9. **(3)** The department will not make a final determination for an applicant, caregiver or hospital caregiver with a pending potentially disqualifying conviction for which no final disposition has been made. In instances of a pending potentially disqualifying conviction for which no final disposition has been made, the department shall notify the care provider, applicant, caregiver or hospital caregiver by certified mail that an employment clearance has not been granted. The Care Provider shall then follow the procedure of Subsection A, of Section 7.1.9.9. **B. Employment Pending Reconsideration Determination:** At the discretion of the care provider, an applicant, caregiver or hospital caregiver whose nationwide criminal history record reflects a disqualifying conviction and who has requested administrative reconsideration may continue conditional supervised employment pending a determination on reconsideration. **NMAC 7.1.9.11 DISQUALIFYING CONVICTIONS.** The following felony convictions disqualify an applicant, caregiver or			

hospital caregiver from employment or contractual services with a care provider: **A.** homicide; **B.** trafficking, or trafficking in controlled substances; **C.** kidnapping, false imprisonment, aggravated assault or aggravated battery; **D.** rape, criminal sexual penetration, criminal sexual contact, incest, indecent exposure, or other related felony sexual offenses; **E.** crimes involving adult abuse, neglect or financial exploitation; **F.** crimes involving child abuse or neglect; **G.** crimes involving robbery, larceny, extortion, burglary, fraud, forgery, embezzlement, credit card fraud, or receiving stolen property; or **H**. an attempt, solicitation, or conspiracy involving any of the felonies in this subsection.			

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Condition of Participation 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 employee prior to employment. Such documentation must include evidence, based on	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 10 of 24 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Personnel (DSP):** • #201 – Date of hire 1/20/2015. • #202 – Date of hire 1/20/2015. • #207 – Date of hire 1/4/2015. • #209 – Date of hire was not provided by the agency. • #212 – Date of hire 1/20/2015. • #214 – Date of hire 3/28/2013. • #217 – Date of hire 10/20/2014. • #222 – Date of hire 2/4/2015. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):**	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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.	• #215 – Date of hire 4/1/2014, completed 5/19/2014. • #219 – Date of hire 3/4/2014, completed 3/6/2014. **Service Coordination Personnel (SC):** • #223 – Date of hire was not provided by the agency; COR completed 3/15/2011.		

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:** **(1)** The community-based service provider shall conduct training or designate a	Based on record review and interview, the Agency did not ensure Incident Management Training for 7 of 24 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect and Exploitation) (DSP# 201, 203, 207, 208, 210, 213, 217)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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.			

Tag # 1A36 Service Coordination Requirements	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: K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training: 1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency. 2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency. 3. Level I – must be completed within one (1) year of assignment to his/her position with the agency. **NMAC 7.26.5.7** "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency **NMAC 7.26.5.11** (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the	Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 1 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Person Centered Planning (2-Day) (SC #223) • Sexuality for People with Developmental Disabilities (SC #223)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows: (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations; (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations; (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports; (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;			

Tag # 1A37 Individual Specific Training	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 status to the DDSD Statewide Training Database as specified in the DDSD Policy T-	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 ensure that Individual Specific Training requirements were met for 10 of 24 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (DSP #202, 204, 208, 209, 210, 212, 213, 214, 219, 221)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

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

about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;			

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 # 1A03 CQI System	**Standard Level Deficiency**		
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met**.** The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include: i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes;	Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard. Review of the Agency's CQI Plan revealed the following: • The Agency's CQI Plan contained the required components, yet there was no written evidence of implementation of the plan indicating the following areas were tracked and trended as required. No evidence of quarterly CQI meeting minutes were presented to the team. a. **Implementation of ISPs:** extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; • Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes • Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

iii. The types of information used to measure performance; and, iv. The frequency with which performance is measured. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements: J. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:	b. Analysis of General Events Reports data in Therap; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns/Trends of reportable incidents; g. Results of improvement actions taken in previous quarters; h. Sufficiency of staff coverage; i. Action taken regarding individual grievances; j. Results of General Events Reporting data analysis, Trends in category II significant events; k. Presence and completeness of required documentation; l. Significant program changes. m. A description of how data collected as part of the agency's QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; and n. Patterns / Trends in medication errors		

a. **Implementation of ISPs:** extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Analysis of General Events Reports data in Therap; b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns of reportable incidents; f. Results of improvement actions taken in previous quarters; g. Sufficiency of staff coverage; h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes; i. Results of General Events Reporting data analysis; j. Action taken regarding individual grievances; k. Presence and completeness of required documentation; **l.** A description of how data collected as part of the agency's QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and	• Review of the Agency's Quality Improvement plan additionally did not contain the following Incident Management specific areas: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;		

remediation of any service delivery deficiencies discovered through the QA/QI process; and **m.** Significant program changes. **CHAPTER 6 (CCS) 3. Agency Requirements: I. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QI Committee:** The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following: a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope,			

amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and g. Significant program changes.			

CHAPTER 7 (CIHS) 3. Agency Requirements: G. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. **Implementation of ISPs:** The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such			

implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation;			

f. A description of how data collected as part of the agency's QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and **g.** Significant program changes. **CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program:** Family Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities. 1. **Development of a QA/QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies,			

trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns in reportable incidents; and g. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis, Trends in category II significant events; d. Patterns in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation;			

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

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

g. A description of how data collected as part of the agency's QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. **CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical			

Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following: a. Implementation of the ISPs, including the extent to which services are delivered in accordance with the ISPs and associated support plans and /or WDSI including the type, scope, amount, duration, and frequency specified in the ISPs as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Trends in General Events as defined by DDSD; c. Compliance with Caregivers Criminal History Screening Requirements; d. Compliance with DDSD training requirements; e. Trends in reportable incidents; and f. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes: a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes; c. Trends in reportable incidents; d. Trends in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. How data collected as part of the agency's QA/QI was used, what quality improvement			

initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. **CHAPTER 14 (ANS) 3. Service Requirements: N. Quality Assurance/Quality Improvement (QA/QI) Program:** Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities. 1. **Development of a QI plan:** The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. 2. **Implementing a QA/QI Committee:** The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting			

shall be documented. The QA review should address at least the following: a. Trends in General Events as defined by DDSD; b. Compliance with Caregivers Criminal History Screening Requirements; c. Compliance with DDSD training requirements; d. Trends in reportable incidents; and e. Results of improvement actions taken in previous quarters. 3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarizes: a. Sufficiency of staff coverage; b. Trends in reportable incidents; c. Trends in medication errors; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and g. Significant program changes **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service			

provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A07 Social Security Income (SSI) Payments	Standard Level Deficiency		
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. C. Provider Agency Financial Records and Accounting: Each individual served will be presumed able to manage his or her own funds unless the ISP documents justified limitations or supports for self-management, and where appropriate, reflects a plan to increase this skill. All Provider Agencies shall maintain and enforce written policies and procedures regarding the use of the individual's SSI payments or other personal funds, including accounting for all spending by the Provider Agency, and outlining protocols for fulfilling the responsibilities as representative payee if the agency is so designated for an individual. **Code of Federal Regulations:** **§416.635 What are the responsibilities of your representative payee…** A representative payee has a responsibility to: (a) Use the benefits received on your behalf only for your use and benefit in a manner and for the purposes he or she determines under the guidelines in this subpart, to be in your best interests; (b) Keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or	Based on record review and interview, the Agency did not maintain and enforce written policies and procedures regarding the use of individuals' SSI payments or other personal funds. Review of the Agency's policies and procedures found no evidence indicating the policy addressed Separate Accounts for Individuals SSI payments or other personal funds. Per Federal code representative payees are to keep any benefits received on your behalf separate from his or her own funds and show your ownership of these benefits unless he or she is your spouse or natural or adoptive parent or stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement; **When administrative personnel was asked about representative payee and their process the following was reported:** • #224 stated, "#2 does not have a checking account his money is kept cash on hand. All social security payments go directly to the agency for rent, consumer does not pay utilities the agency pays that. After the rent is paid then the remaining balance goes into their account accept for #2." • #225 stated, "Social Security Payments are deposited into one account and then the rent is paid, the remaining balance goes into the individual accounts."	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

stepparent and lives in the same household with you or is a State or local government agency for whom we have granted an exception to this requirement; (c) Treat any interest earned on the benefits as your property; (d) Notify us of any event or change in your circumstances that will affect the amount of benefits you receive, your right to receive benefits, or how you receive them; (e) Submit to us, upon our request, a written report accounting for the benefits received on your behalf, and make all supporting records available for review if requested by us; (f) Notify us of any change in his or her circumstances that would affect performance of his/her payee responsibilities; and §416.640 Use of benefit payments. ***Current maintenance***. We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes costs incurred in obtaining food, shelter, clothing, medical care and personal comfort items. **§416.665 How does your representative payee account for the use of benefits…** Your representative payee must account for the use of your benefits. We require written reports from your representative payee at least once a year (except for certain State institutions that participate in a separate onsite review program). We may verify how your representative payee used your benefits. Your representative payee should keep records of how benefits were used in order to make accounting reports and must make those records available upon our request.			

Tag # 1A09 **Medication Delivery** **Routine Medication Administration**	**Condition of Participation 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 ➢ the exact amount to be used in a 24 hour period.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Medication Administration Records (MAR) were reviewed for the months of January and March 2015. Based on record review, 7 of 7 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #1 January 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Keppra 1000 mg (2 times daily) • Keppra 750 mg (1 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Divalproex 500 mg was marked through and 1,000 hand written (2 times daily) • Keppra 750 mg (1 times daily) March 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Keppra 1000 mg (1 time daily) • Keppra 750 mg (1 time daily)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8.** Providing assistance with medication delivery as outlined in the ISP; **C. Individual Community Integrated Employment 3.** Providing assistance with medication delivery as outlined in the ISP; **D. Group Community Integrated Employment 4.** Providing assistance with medication delivery as outlined in the ISP; and **B. Community Integrated Employment Agency Staffing Requirements: o.** Comply with DDSD Medication Assessment and Delivery Policy and Procedures; **CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **C. Small Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **D. Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **CHAPTER 11 (FL) 1 SCOPE OF SERVICES A. Living Supports- Family Living Services:** The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): **19.** Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for	Individual #2 January 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Clotrimazole 1% (2 times daily) • Depakote ER 250 mg (2 times daily) • Melatonin 3mg (1 time daily) • Omeprazole 20 mg (1 time daily) • Quetiapine 200 mg (1 time daily) • Quetiapine 100 mg (1 time daily) • Sertraline 100 mg (1 time daily) • Triaminoclone Acetonide 0.1% (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Clotrimazole 1% (2 times daily) • Melatonin 3mg (1 time daily) • Triaminoclone Acetonide 0.1% (2 times daily) March 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Clotrimazole 1% Cream (2 times daily)		

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;	• Depakote ER 250 mg (2 times daily) • Melatonin 3 mg (1 time daily) • Omeprazole 20 mg (1 time daily) • Quetiapine 100 mg (1 time daily) • Quetiapine 200 mg (1 time daily) • Sertraline 100 mg (1 time daily) • Sertraline 50 mg (1 time daily) Individual #5 January 2015 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Quetiapine 100 MG (3 times daily) – Blank 1/26, 29 (12 PM) • Erythromycin/Benzamycin.Perox Gel (2 times daily) – Blank 1/31 (6 PM) • Mupirocin 2% (3 times daily) – Blank 1/1 - 31 (7AM, 4PM, 10PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Acyclovier 400 mg (1 time daily) • Clonidine HCL 0.1 (1 time daily) • Escitalopram 10 mg (1 time daily) • Escitalopram 20 mg (1 time daily) • Flunisolide 0.025 % (2 times daily)		

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.	• Folic Acid 1 mg (1 time daily) • Melatonin 5 mg (1 time daily) • Mupirocin 2% (3 times daily) • Omeprazole 20 mg (1 time daily) • Quetiapine 200 mg (1 time daily) • Quetiapine 100 mg (3 time daily) • Trazadone 50 mg (1 time daily) • Vitamin B 12 1000 mcg (1 time daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Escitalopram 10 mg (1 time daily) • Quetiapine 200 mg (1 time daily) • Vitamin D 50 mg (1time daily) • Accuflora (missing) (2 times daily) March 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Acyclovier 400 mg (1 time daily) • Clonidine HCL 0.1 (1 time daily) • Escitalopram 10 mg (1 time daily) • Escitalopram 20 mg (1 time daily) • Flunisolide 0.025 % (2 times daily)		

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	• Folic Acid 1 mg (1 time daily) • Melatonin 5 mg (1 time daily) • Omeprazole 20 mg (1 time daily) • Quetiapine 200 mg (1 time daily) • Trazadone 50 mg (1 time daily) • Vitamin B 12 1000 mcg (1 time daily) Individual #6 January 2015 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Polyethylene Glyco 3350NF (1 time daily) – Blank 1/1 - 31 (8 AM) • Astelin 137MCG (2 times daily) – Blank 1/1 - 31 • Chlorhexidine .12% (2 times weekly) – Blank 1/1 - 31 Medication Administration Record did not contain the time the medication should be given. MAR was blank in time section: • Astelin 137MCG (2 times daily) – Blank 1/1 - 31. • Chlorhexidine .12% (2 times weekly) – Blank 1/1 – 31. Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Divaproex 500mg ER (2 times daily)		

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	• Fish Oil 1000mg (2 times daily) • Keppra 250mg (2 times daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Tums 500 (2 times daily) • Multivitamin (1 time daily) March 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Divaproex 500mg ER (2 times daily) • Fish Oil 1000mg (2 times daily) • Keppra 250mg (2 times daily) Individual #7 January 2015 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Keppra 750mg (2 times daily) – Blank 1/02 - 31 (8AM, 6PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 5mg (1 time daily) • Fluticasone Prop. 50mcg (1 time daily) • Jolivette (1 time daily) • Keppra 750mg (2 times daily)		

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;	• Lisinopril 10 mg (1 time daily) • Topiramate 25 mg (2 times daily) • Tums 500mg (4 times daily) • Levocarnitine 330 mg (3 times daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Jolivette (1 time daily) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Keppra 750mg (2 times daily) March 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Abilify 5mg (1 time daily) • Jolivette (1 time daily) • Keppra 750mg (2 times daily) • Lisinopril 10 mg (1 time daily) • Topiramate 25 mg (2 times daily) • Erythromycin 2% (2 times daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Jolivette (1 time daily) • Multivitamin (1 time daily)		

(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;	Individual #8 January 2015 During on-site survey Medication Administration Records were requested for months of January 2015. As of 3/4/2015, Medication Administration Records for January had not been provided. During on-site survey Physician Orders were requested. As of 3/4/2015, Physician Orders had not been provided. March 2015 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Amlodipine-Benazepril 5-40 mg (1 time daily) • Aspirin 81mg (1 time daily) • Fiber Choice (1 time daily) • Hydrochlorothiazide 12.5 mg (1 time daily) • Lisinopril 40 mg (1 time daily) • Loratadine 10mg (1 time daily) • Multivitamin (1 time daily) • Simvastatin 20 mg (1 time daily) • Calcium 500 (2 times daily) • Econazole Nitrate 1 % (2 times daily) • Metformin HCL 500mg (2 times daily) • Clonazepam 1mg (3 times daily)		

	• Hydroxyzine HCL 25mg (4 times daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Fiber Choice Tablet (1 time daily) • Multivitamin (1 time daily) Individual #9 January 2015 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Docusate SOD 150MG/15ML (2 times daily) – Blank 1/1 - 31 (8AM and 6PM) Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Clobazam (ONFI) 10mg (2 times daily) • Levothyroxine 25mcg (1 time daily) • Lorazepam 1MG (2 times daily) • Trazadone 50mg (1 time daily) • Zonisamide 100mg (2 times daily)		

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 ➢ the exact amount to be used in a 24 hour period.	Medication Administration Records (MAR) were reviewed for the months of January and March, 2015. Based on record review, 2 of 7 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #5 January 2015 Medication Administration Records did not contain the exact amount to be used in a 24 hour period: • Tums 750mg (PRN) • Robitussin (PRN) • Ibuprofen (PRN) Medication Administration Records contain the following medications. No Physician's Orders were found for the following medications: • Albuterol .83mg/ml Solution (PRN) • Ventolin HFA 90MCG Inhaler (PRN) • Mypirocen 2% Ointment Bactroban (PRN) • Bezonate 100mg Capsule (PRN) • Ajotwir 800Tab (PRN) Individual #8 March 2015 During home visit on 3/2/2015 at 7PM observation of medications found the following	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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	controlled medications in the home, yet no MARs were found for the following PRN medication: • Hydrocodon-Acetaminophen 5 - 325mg (PRN) • Oxycodone ACET 5-325mg (PRN)		

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 # 1A11 Transportation Policy and Procedure	Standard Level Deficiency		
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 2. APPLICABLE LAWS: This Provider Agreement shall be governed by the laws of the State of New Mexico. **Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy:** Training Requirements for Direct Service Agency Staff Policy **Eff Date:** March 1, 2007 **II. POLICY STATEMENTS:** 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 services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre-trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency)	Based on record review, the Agency did not have written policies and procedures regarding the safe transportation of individuals in the community, which comply with New Mexico regulations governing the operation of motor vehicles to transport individuals. Review of Agency's policies and procedures indicated the following elements were not found: (1) Operating a fire extinguisher (7) Emergency Plans, including vehicle evacuation techniques,	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) I. Scope of Services A. Job Development: 11.** Arranging or providing transportation during Job Development activities; and **B. Self Employment**: 7. Arranging or providing transportation during Job Development activities; and **C. Integrated Employment Services: 2.** Arranging or providing transportation or supporting public transportation during Individual Community Integrated Employment Services; **Integrated Employment Services: D. 3.** Arranging or providing transportation or supporting public transportation during Group Community Integrated Employment Services; **CHAPTER 6 (CCS) I. Scope of Service A. Individualized Customized Community Supports** 17. Providing transportation or assisting with transportation arrangements for participating in Customized Community Supports; **C. Small Group Customized Community Supports** 17. Providing or assisting with transportation during provision of Customized Community Supports; **D. Group Customized Community Supports** 17. Providing or assisting with transportation during provision of Customized Community Supports; **CHAPTER 11 (FL) 2. Service Requirements: I. Healthcare Requirements for Family Living: 10.** Family Living provider agencies must have a written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety". The policy and			

procedures must address at least the following topics: **a.** Drivers' requirements; **b.** Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions; **c.** Vehicle maintenance and safety inspections; **d.** DSP training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures; **e.** Emergency Plans, including vehicle evacuation techniques; **f.** Accident Procedures; and **g.** Written documentation of vehicle maintenance, safety inspections, and staffing training. **CHAPTER 12 (SL) 2. Service Requirements: L. Training and Requirements 7. Transportation:** Supported Living provider agencies must have a written policy and procedures regarding the safe transportation of individuals in the community, and comply with New Mexico regulations governing the operation of motor vehicles to transport individuals, and which are consistent with DDSD guidelines issued July 1, 1999 titled "Client Transportation Safety." The policy and procedures must address at least the following topics: a. Drivers' requirements; b. Individual safety, including safe locations for boarding and disembarking passengers, appropriate responses to hazardous weather and other adverse driving conditions; c. Vehicle maintenance and safety inspections; d. DSP training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures; e. Emergency Plans, including vehicle evacuation techniques;			

f. Accident Procedures; and g. Written documentation of vehicle maintenance, safety inspections, and staffing training. **CHAPTER 13 (IMLS) 2. Service Requirements: N.** Services provider agencies must develop and implement policies and procedures regarding the safe transportation of individuals in the community which comply with New Mexico regulations governing operation of motor vehicles to transport individuals and which are consistent with DDSD guidelines issued July 1, 1999 titled “Client Transportation Safety”. The policy and procedures must address at least the following: 1. Documented evidence of driver requirements; 2. Individual safety including locations for boarding and disembarking passengers, and appropriate response to hazardous weather and other adverse driving conditions, including securing all equipment and supplies needed to assure health and safety during transport; 3. Vehicle maintenance and safety inspections; 4. Documented evidence of driver training regarding safe operation of the vehicle, assisting passengers, and safe lifting procedures; 5. Emergency plans including vehicle evacuation techniques; and 6. Accident procedures.			

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Condition of Participation 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. **I. Health Care Requirements for Family Living:** **5.** A nurse employed or contracted by the Family Living Supports provider must complete the e-	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 9 of 9 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • Electronic Comprehensive Health Assessment Tool (eCHAT) (#1, 2, 4, 8) • Medication Administration Assessment Tool (#2, 4) • Aspiration Risk Screening Tool (#4) • **Quarterly Nursing Review of HCP/Medical Emergency Response Plans:** ° None found for 2/2014 - 4/2014; 5/2014-7/2014 and 8/2014 – 10/2014 (#3) ° None found for 12/2013 - 2/2014; 3/2014-5/2014; 6/2014 – 8/2014 and 9/2014-11/2014 (#6) • **Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:** ° None found for 2/2014 - 8/2014 and 8/2014 – 2/2015 (#1) ° None found for 2/2014 - 7/2014 and 8/2014 1/2015 (#2)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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	° None found for 12/2013 - 12/2014 (#4) ° None found for 10/2013 - 5/2014 (#7) ° None found for 8/2014 - 1/2015 (#8) • **Special Health Care Needs:** • *Nutritional Plan* ° Individual #3 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ° Individual #7 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • *Prader Willi* ° Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • **Health Care Plans** • *Body Mass Index* Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Endocrine/Diabetes* Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Falls* Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Insulin Administration*		

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	Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Respiratory* Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Skin and Wound* Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Status of Oral Hygiene* Individual #2 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • **Medical Emergency Response Plans** • *Diabetes/Endocrine* Individual #4 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Neuro Device /Seizure* Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. Plan was not signed or dated.		

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:	• *Respiratory* ° Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Seizure* Individual #1 - As indicated by the IST section of ISP the individual is required to have a plan. Plan was not signed or dated. ° Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ° Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.		

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 # 1A27 Incident Mgt. Late and Failure to Report	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of	Based on the Incident Management Bureau's Late and Failure Reports, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement, as required by regulations for 3 of 9 individuals. Individual #1 • Incident date 3/8/2014. Allegation was Abuse/ Neglect, Emergency Services, Law Enforcement involvement. Incident report was received on 3/19/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." Individual #6 • Incident date 4/23/2014. Allegation was Neglect. Incident report was received on 4/29/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." Individual #7 • Incident date 5/7/2014. Allegation was Neglect, Emergency Services. Incident report was received on 5/9/2014. IMB issued a Late Reporting for Neglect, Emergency Services.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form. **(3) Limited provider investigation:** No investigation beyond that necessary in order to			

be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the alleged incident unless the parent or legal guardian is suspected of committing the			

alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation			

Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications:** **(1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the	Based on record review, the Agency did not report suspected abuse, neglect, or exploitation, unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 9 Individuals. During the on-site survey the week of 3/2/2015, surveyors observed the following: During the on-site visit at the Administrative Building/Customized Community Supports/Day Hab Center, Surveyors were located in the front open area next to SC #223's desk. On 03/3/2015, Surveyor's witnessed Individual #8 being treated disrespectfully by SC #223. Prior to the incident SC #223 was on the telephone speaking with DSP #210. From what surveyors could hear from the conversation, Individual #8 was displaying behaviors out in the community. SC #223 directed DSP #210 to bring the individual into the center. Individual #8 entered the center and was visibly upset. A few minutes passed and DSP# 210 walked in after Individual #8. In a harsh voice, SC #223 stated to Individual #8, "that's why there is freedom of choice so that you can find somewhere else to go." SC #223 continued to antagonize Individual #8 walking behind him as he left the front area to the back of the center where Day Hab is located by telling him that he will not have an attitude up front and he needed to go to the back room. After Individual #8 was directed to the back where the day program is located, Surveyors were informed that Individual #8 was requesting to speak to "the state" regarding an incident that had just occurred in the community. Although	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.	surveyors conducted a home visit on 03/02/2015 at 7PM, they were unable to interview Individual #8 as he was asleep at the time of the visit. At approximately 2:38 pm on 03/03/2015, a surveyor was assigned to speak to Individual #8 and document the interview. During that interview, Individual #8 reported his direct care staff was verbally abusive and threating him while on an outing in the community. As a result of what was observed and reported by individual #8 the following incident(s) was reported: Individual #8 • A State Incident Report of Abuse was filed on 3/3/2015. Incident report was reported to Division of Health Improvement.		

(3) Limited provider investigation: No investigation beyond that necessary in order to be able to report the abuse, neglect, or exploitation and ensure the safety of consumers is permitted until the division has completed its investigation. **(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall: **(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable; **(b)** be immediately prepared to report that immediate action and safety plan verbally, and revise the plan according to the division's direction, if necessary; and **(c)** provide the accepted immediate action and safety plan in writing on the immediate action and safety plan form within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted by faxing it to the division at 1-800-584-6057. **(5) Evidence preservation:** The community-based service provider shall preserve evidence related to an alleged incident of abuse, neglect, or exploitation, including records, and do nothing to disturb the evidence. If physical evidence must be removed or affected, the provider shall take photographs or do whatever is reasonable to document the location and type of evidence found which appears related to the incident. **(6) Legal guardian or parental notification:** The responsible community-based service provider shall ensure that the consumer's legal guardian or parent is notified of the alleged incident of abuse, neglect and exploitation within 24 hours of notice of the			

alleged incident unless the parent or legal guardian is suspected of committing the alleged abuse, neglect, or exploitation, in which case the community-based service provider shall leave notification to the division's investigative representative. **(7) Case manager or consultant notification by community-based service providers:** The responsible community-based service provider shall notify the consumer's case manager or consultant within 24 hours that an alleged incident involving abuse, neglect, or exploitation has been reported to the division. Names of other consumers and employees may be redacted before any documentation is forwarded to a case manager or consultant. **(8) Non-responsible reporter:** Providers who are reporting an incident in which they are not the responsible community-based service provider shall notify the responsible community-based service provider within 24 hours of an incident or allegation of an incident of abuse, neglect, and exploitation			

Tag # 1A28 Incident Mgt. System - Policy/Procedure	Standard Level Deficiency		
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **D. Incident policies:** All community-based service providers shall maintain policies and procedures which describe the community-based service provider's immediate response, including development of an immediate action and safety plan acceptable to the division where appropriate, to all allegations of incidents involving abuse, neglect, or exploitation, suspicious injury as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC. **E. Retaliation:** Any person, including but not limited to an employee, volunteer, consultant, contractor, consumer, or their family members, guardian, and another provider who, without false intent, reports an incident or makes an allegation of abuse, neglect, or exploitation shall be free of any form of retaliation such as termination of contract or employment, nor may they be disciplined or discriminated against in any manner including, but not limited to, demotion, shift change, pay cuts, reduction in hours, room change, service reduction, or in any other manner without justifiable reason. **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written	Based on record review, the Agency did not establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. During on-site survey, the following was found: • The Agency's policy was not updated to the current NMAC 7.1.14 which was effective July 2, 2014. The agency's policy contained the previous version.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.			

Tag # 1A28.2 **Incident Mgt. System - Parent/Guardian Training**	**Condition of Participation Level Deficiency**		
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. **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	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 provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 8 of 9 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#1, 2, 3, 4, 5, 7, 8, 9)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # 1A29 Complaints / Grievances Acknowledgement	Standard Level Deficiency		
NMAC 7.26.3.6 A These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	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 provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 8 of 9 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Grievance/Complaint Procedure Acknowledgement (#1, 2, 3, 4, 5, 7, 8, 9)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # LS13 / 6L13 Community Living Healthcare Reqts.	Condition of Participation 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 (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING**	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 provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 5 of 7 individuals receiving Community Living Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • ***Annual Physical*** (#1, 2, 5, 8, 9) • ***Dental Exam*** ◦ Individual # 2 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual # 5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual # 8 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. Additionally, review of the ISP indicated the individual has a history of Oral Cancer and must have required screenings and exams. ◦ Individual # 9 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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.	• ***Vision Exam*** ° Individual #2 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #5 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #8 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #9 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. • ***Auditory Exam*** ° Individual #8 - As indicated by the Health and Safety Section of the Individual Service Plan, the exam is to be completed every 5 years per physician's recommendation. No evidence of the exam results were found. • ***Bone Density Exam*** ° Individual #8 - As indicated by the Health and Safety Section of the Individual Service Plan, the exam is to be completed every 5 years per physician's recommendation. No evidence of the exam results were found. ▪ ***Cholesterol and Blood Glucose*** ° Individual #9 - As indicated by the Health and Safety Section of the Individual Service Plan, lab work is to be completed annually per Physicians Recommendation. No evidence of lab results were found.		

(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).	• ***Blood Levels*** ◦ Individual #1 - As indicated by physician's progress notes from 12/1/2014 the individual has had an increase in seizures and is required follow up blood test to determine the level of Depakote and Keppra levels. No evidence of lab results were found. ◦ Individual #9 - As indicated by the Health and Safety Section of the Individual Service Plan, lab work ***(hypothyroidism)*** is to be completed annually. No evidence of lab results were found. • ***Review of Psychotropic Medication*** ◦ Individual #2 - No evidence was found for the following time frame to indicate they were completed (11/2013 - 3/2015). • ***Involuntary Movement Evaluations and/or Tardive Dyskinesia Screenings*** ◦ None found 3/2014 - 3/2015 for Depakote ER and Seroquel (#2)		

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Condition of Participation 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: j. Maintain basic utilities, i.e., gas, power, water and telephone; k. 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; l. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; m. Have a general-purpose first aid kit; n. 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; o. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; p. Have accessible written procedures for the safe storage of all medications with	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 5 of 5 Supported Living 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:** • Maintain basic utilities; the individual did not have access to a house phone or a cellular phone (#8) • Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#1, 2) • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 145^0 F (#1,2) *(Note: finding was corrected during the on-site survey; original home visit completed 03/02/2015, rechecked 03/04/2015 measured 110^0 F)* ➢ Water temperature in home measured 122^0 F (#5, 6) ➢ Water temperature in home measured 124.7^0 F (#7) ➢ Water temperature in home measured 125^0 F (#8)	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and q. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services:** 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must: 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;	➢ Water temperature in home measured 126^0 F (#9) • General-purpose first aid kit (#1, 2, 7, 8) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 2, 7, 8, 9) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2, 7, 9) • 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, 2, 7, 8, 9) *Note: The following Individuals share a residence:* ➢ #1,2 ➢ #5,6		

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 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. 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 # 5I44 **Adult Habilitation Reimbursement**	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004** **8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Adult Habilitation Services for 2 of 2 individuals. Individual #3 November 2014 • The Agency billed 46 units of Adult Habilitation (T2021 U1) on 11/2/2014. No documentation received accounting for 0 units. • The Agency billed 24 units of Adult Habilitation (T2021 U1) on 11/10/2014. Documentation received accounted for 22 units. • The Agency billed 96 units of Adult Habilitation (T2021 U1) from 11/18/2014 through 11/21/2014. Documentation received accounted for 94 units. • The Agency billed 26 units of Adult Habilitation (T2021 U1) on 11/24/2014. No documentation received accounting for 0 units. December 2014 • The Agency billed 48 units of Adult Habilitation (T2021 U1) from 12/18/2014 through 12/19/2014. Documentation received accounted for 46 units. January 2015	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 XVI. REIMBURSEMENT** **A. Billable Unit**. A billable unit for Adult Habilitation Services is in 15-minute increments hour. The rate is based on the individual's level of care. **B. Billable Activities** (1) The Community Inclusion Provider Agency can bill for those activities listed and described on the ISP and within the Scope of Service. Partial units are allowable. Billable units are face-to-face, except that Adult Habilitation services may be non- face-to-face under the following conditions: (a) Time that is non face-to-face is documented separately and clearly identified as to the nature of the activity; and(b) Non face-to-face hours do not exceed 5% of the monthly billable hours. (2) Adult Habilitation Services can be provided with any other services, insofar as the services are not reported for the same hours on the same day, except that Therapy Services and Case Management may be provided and billed for the same hours	• The Agency billed 24 units of Adult Habilitation (T2021 U1) on 1/1/2015. No documentation received accounting for 0 units. • The Agency billed 48 units of Adult Habilitation (T2021 U1) from 1/6/2015 through 1/7/2015. Documentation received accounted for 47 units. Individual #6 January 2015 • The Agency billed 52 units of Adult Habilitation (T2021 U2) from 1/1/2015 through 1/2/2015. No documentation received accounting for 0 units. • The Agency billed 28 units of Adult Habilitation (T2021 U2) on 1/5/2015. No documentation received accounting for 0 units. • The Agency billed 108 units of Adult Habilitation (T2021 U2) from 1/6/2015 through 1/9/2015. No documentation received accounting for 0 units. • The Agency billed 28 units of Adult Habilitation (T2021 U2) from 1/12/2015 through 1/15/2015. No documentation received accounting for 0 units. • The Agency billed 28 units of Adult Habilitation (T2021 U2) on 1/19/2015. No documentation received accounting for 0 units. • The Agency billed 112 units of Adult Habilitation (T2021 U2) from 1/27/2015 through 1/30/2015. No documentation received accounting for 0 units.		

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:** 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.	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Customized Community Supports for 2 of 6 individuals. Individual #2 January 2015 • The Agency billed 112 units of Customized Community Supports (group) (T2021 HBU8) from 1/27/2015 through 1/30/2015. Documentation received accounted for 56 units. Individual #9 November 2014 • The Agency billed 140 units of Customized Community Supports (group) (T2021 HBU8) from 11/3/2014 through 11/7/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 11/10/2014. No documentation received accounting for 0 units. • The Agency billed 112 units of Customized Community Supports (group) (T2021 HBU8) from 11/11/2014 through 11/14/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 11/17/2014. No documentation received accounting for 0 units.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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	• The Agency billed 112 units of Customized Community Supports (group) (T2021 HBU8) from 11/18/2014 through 11/21/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 11/24/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 11/26/2014. No documentation received accounting for 0 units. December 2014 • The Agency billed 138 units of Customized Community Supports (group) (T2021 HBU8) from 12/1/2014 through 12/5/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 12/8/2014. No documentation received accounting for 0 units. • The Agency billed 112 units of Customized Community Supports (group) (T2021 HBU8) from 12/9/2014 through 12/12/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 12/15/2014. No documentation received accounting for 0 units. • The Agency billed 112 units of Customized Community Supports (group) (T2021 HBU8) from 12/16/2014 through 12/19/2014. No		

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.	documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 12/22/2014. No documentation received accounting for 0 units. • The Agency billed 56 units of Customized Community Supports (group) (T2021 HBU8) from 12/23/2014 through 12/24/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 12/26/2014. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 12/29/2014. No documentation received accounting for 0 units. January 2015 • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 1/1/2015. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8) on 1/5/2015. No documentation received accounting for 0 units. • The Agency billed 112 units of Customized Community Supports (group) (T2021 HBU8) from 1/6/2015 through 1/9/2015. No documentation received accounting for 0 units. • The Agency billed 28 units of Customized Community Supports (group) (T2021 HBU8)		

	on 1/12/2015. No documentation received accounting for 0 units. • The Agency billed 95 units of Customized Community Supports (group) (T2021 HBU8) from 1/13/2015 through 1/16/2015. No documentation received accounting for 0 units. • The Agency billed 24 units of Customized Community Supports (group) (T2021 HBU8) on 1/19/2015. No documentation received accounting for 0 units. • The Agency billed 104 units of Customized Community Supports (group) (T2021 HBU8) from 1/27/2015 through 1/30/2015. No documentation received accounting for 0 units.		

Tag # LS26 / 6L26 **Supported Living Reimbursement**	**Standard Level Deficiency**		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 12 (SL) 2. REIMBURSEMENT** **A.** Supported Living 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 Supported Living Services Provider Agency records must be sufficiently detailed to substantiate the date, time, individual name, servicing provider, nature of services, and length of a session of service billed. 3. The documentation of the billable time spent with an individual must 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 must 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; c. The signature or authenticated name of staff providing the service; d. The rate for Supported Living is based on categories associated with each individual's NM DDW Group; and e. A non-ambulatory stipend is available for those who meet assessed need requirement. **B. Billable Units:** 1. The billable unit for Supported Living is based on a daily rate. A day is determined	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Living Services for 4 of 7 individuals. Individual #1 January 2015 • The Agency billed 1 unit of Supported Living (T2016 HBU5) on 1/9/2015. No documentation received accounting for 0 units. • The Agency billed 1 unit of Supported Living (T2016 HBU5) on 1/13/2015. No documentation received accounting for 0 units. • The Agency billed 1 unit of Supported Living (T2016 HBU5) on 1/30/2015. No documentation received accounting for 0 units. Individual #7 December 2014 • The Agency billed 1 units of Supported Living (T2016 HBU6) from on 12/1/2014. No documentation received accounting for 0 units. • The Agency billed 1 units of Supported Living (T2016 HBU6) from on 12/2/2014. No documentation received accounting for 0 units. Individual #8 January 2015 • The Agency billed 19 units of Supported Living (T2016 HBU6) from 1/1/2015 through 1/19/2015. No documentation received accounting for 0 units.	**Provider:** State your Plan of Correction for the deficiencies cited in this tag here: → **Provider:** Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

based on whether the individual was residing in the home at midnight. 2. The maximum allowable billable units cannot exceed three hundred forty (340) calendar days per ISP year or one hundred seventy (170) calendar days per six (6) months. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION** **A. General:** All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed. **B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following: (1) Date, start and end time of each service encounter or other billable service interval; (2) A description of what occurred during the encounter or service interval; and (3) The signature or authenticated name of staff providing the service. **MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** Providers must maintain all records necessary to fully disclose the extent of the services	• The Agency billed 5 units of Supported Living (T2016 HBU6) from 1/27/2015 through 1/31/2015. No documentation received accounting for 0 units. Individual #9 January 2015 • The Agency billed 19 units of Supported Living (T2016 HBU6) from 1/1/2015 through 1/19/2015. No documentation received accounting for 0 units. • The Agency billed 5 units of Supported Living (T2016 HBU6) from 1/27/2015 through 1/31/2015. No documentation received accounting for 0 units.		

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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. IX. REIMBURSEMENT FOR COMMUNITY LIVING SERVICES** A. **Reimbursement** for Supported Living Services (1) Billable Unit. The billable Unit for Supported Living Services is based on a daily rate. The daily rate cannot exceed 340 billable days a year. (2) **Billable Activities** (a) Direct care provided to an individual in the residence any portion of the day. (b) Direct support provided to an individual by community living direct service staff away from the residence, e.g., in the community. (c) Any activities in which direct support staff provides in accordance with the Scope of Services. (3) Non-Billable Activities (a) The Supported Living Services provider shall not bill DD Waiver for Room and Board. (b) Personal care, respite, nutritional counseling and nursing supports shall not be billed as separate services for an individual receiving Supported Living Services. (c) The provider shall not bill when an individual is hospitalized or in an institutional care setting.			

Date:	October 2, 2015
To:	LeShelle Harvey, Assistant Director
Provider:	Expressions Unlimited, Co.
Address:	955 San Pedro NE
State/Zip:	Albuquerque, New Mexico 87108
E-mail Address:	Luvshell22@gmail.com Chrishen1390@gmail.com Thelmah1377@gmail.com
Region:	Metro
Survey Date:	March 2 - 4, 2015
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living) *Inclusion Supports* (Customized Community Supports) ***2007:*** *Community Living* (Supported Living) and *Community Inclusion* (Adult Habilitation)
Survey Type:	Routine

Dear Ms. Harvey;

The Division of Health Improvement Quality Management Bureau received and reviewed the documents you submitted for your Plan of Correction. Your Plan of Correction is not closed.

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections. In addition, your agency is being referred to the Internal Review Committee for failure to comply with the Plan of Correction process in a timely manner.

The Quality Management Bureau will be need to conduct a verification survey to ensure previously cited deficiencies have been corrected and that systemic Quality Improvement and Quality Assurance processes have been effective at sustaining corrections.

If the Verification survey determines survey deficiencies have been corrected and corrective measures have effectively maintained compliance with DDW Standards, your Plan of Correction will be considered for closure.

If the Verification survey identifies repeat deficiencies, your case will again be referred to the Internal Review Committee for discussion of possible civil monetary penalties, possible monetary fines and/or other sanctions

Thank you for your cooperation with the Plan of Correction process.

Sincerely,

Amanda Castañeda

Amanda Castañeda
Health Program Manager/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.15.3.DDW.91028761.5.RTN.07.15.275