Date: December 9, 2015

To: Melinda Golden, Interim Chief Executive Officer

Provider: Tohatchi Area of Opportunity & Services, Inc.
Address: 1658 S. 2nd Street
State/Zip: Gallup, New Mexico 87301

E-mail Address: mgolden777@yahoo.com

Region: Northwest
Survey Date: November 16 - 19, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services); *Other* (Customized In-Home Supports)

Survey Type: Routine

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

Team Members: Jesus Trujillo RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Erica Nilsen, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Leslie Peterson BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Golden:

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

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

***Compliance with all Conditions of Participation***.

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

**Plan of Correction:**
The attached Report of Findings identifies the Standard Level and/or Condition of Participation deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction. Your

agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Nicole Brown, MBA

Nicole Brown, MBA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

## Survey Process Employed:

| | |
|---|---|
| Entrance Conference Date: | November 16, 2015 |
| Present: | **Tohatchi Area of Opportunity & Services, Inc.**<br>Trilisia Boone, Service Coordinator<br>Catherine Tsalabutie, Service Coordinator<br>Melinda Golden, Interim Chief Executive Officer<br>Andrea Manuelito, Chief Financial Officer<br>Valerie Leslie, RN<br>Artencia Beyal, Human Resources Manager<br>Kimber Crowe, Training Coordinator<br>Corrine Begody, Individual Service Monitor<br>Carol Charles, Community Skills Coach<br>Tessa Arviso, Health Technician<br><br>**DOH/DHI/QMB**<br>Nicole Brown, MBA, Lead/Healthcare Surveyor<br>Jesus Trujillo, RN, Healthcare Surveyor<br>Lelsie Peterson, BA, Healthcare Surveyor<br>Erica Nilsen, BA, Healthcare Surveyor |
| Exit Conference Date: | November 19, 2015 |
| Present: | **Tohatchi Area of Opportunity & Services, Inc.**<br>Trilisia Boone, Service Coordinator<br>Catherine Tsalabutie, Service Coordinator<br>Melinda Golden, Interim Chief Executive Officer<br>Corrine Begody, Individual Service Monitor<br>Artencia Beyal, Human Resources Manager<br>Andrea Manuelito, Chief Financial Officer<br>Genelle Morris, Residential Supervisor<br>Carol Charles, Community Skills Coach<br>Annette Etsitty, Administrative Assistant/IT<br>Kimber Crowe, Training Coordinator<br>Valerie Leslie, RN<br>Daric Kalleco, Operations Coordinator<br>Erika Yazzie, Health Assistant<br>Tessa Arviso, Health Technician<br><br>**DOH/DHI/QMB**<br>Nicole Brown, MBA, Lead/Healthcare Surveyor<br>Jesus Trujillo, RN, Healthcare Surveyor<br>Lelsie Peterson, BA, Healthcare Surveyor<br><br>**DDSD - NW Regional Office**<br>Crystal Wright, Regional Director<br>Orlinda Charelston, Community Inclusion Coordinator |
| Administrative Locations Visited | Number: 2 |
| Total Sample Size | Number: 17<br><br>0 - *Jackson* Class Members<br>17 - Non-*Jackson* Class Members<br>15 - Supported Living |

| | | |
|---|---|---|
| | | 15 - Customized Community Supports<br>6 - Community Integrated Employment Services<br>2 – Customized In-Home Supports |
| Total Homes Visited | Number: | 8 |
| ❖ Supported Living Homes Visited | Number: | 8<br>*Note: The following Individuals share a SL residence:*<br>➢ #2, 7, 17<br>➢ #3, 16<br>➢ #5, 14<br>➢ #1, 15<br>➢ #6, 10<br>➢ #4, 12<br>➢ #8, 15 |
| Persons Served Records Reviewed | Number: | 17 |
| Persons Served Interviewed | Number: | 6 |
| Persons Served Observed | Number: | 11 (Eleven individuals choose not to participate and one individual was unavailable during on-site survey) |
| Direct Support Personnel Interviewed | Number: | 14 |
| Direct Support Personnel Records Reviewed | Number: | 44 (One DSP record was not reviewed as they were not listed on the agency personnel record, yet, participated in interviews) |
| Service Coordinator Records Reviewed | Number: | 2 |

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

CC: Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General
DOH – Internal Review Committee

**Attachment A**

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

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

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

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

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

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

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

***Instructions for Completing Agency POC:***

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

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

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

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

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

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

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

***Completion Dates***

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

***Initial Submission of the Plan of Correction Requirements***

1. The Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. For questions about the POC process, call the POC Coordinator, Amanda Castaneda at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us *(preferred method)*
    b. Fax to 575-528-5019, or
    c. Mail to POC Coordinator, 1170 North Solano Ste D, Las Cruces, New Mexico 88001

5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
    b. If your POC is denied, it must be revised and resubmitted as soon as possible, as the 45 business day limit is in effect.
    c. If your POC is denied a second time your agency may be referred to the Internal Review Committee.
    d. You will receive written confirmation when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.

***POC Document Submission Requirements***

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

1. Your internal documents are due within a ***maximum*** of 45 business days of receipt of your Report of Findings.
2. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (scanned and attached to e-mails).
3. All submitted documents ***must be annotated***; please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; Please provide copies or scanned electronic files for evidence. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
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:** **Tohatchi Area of Opportunity & Services, Inc. – Northwest Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)
Monitoring Type: Routine Survey
**Survey Date:** **November 16 – 19, 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**<br>**Agency Case File** | **Standard Level Deficiency** | | |
| Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013<br>**Chapter 5 (CIES) 3. Agency Requirements**<br>**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:<br>1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD;<br>2. Career Development Plans as incorporated in the ISP; and<br>3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR).<br><br>**Chapter 6 (CCS) 3. Agency Requirements:**<br>**G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix | Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 17 individuals.<br><br>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>• **ISP Teaching and Support Strategies**<br>◦ *Individual #2 TSS not found for the following Action Steps:*<br>◦ Work/learn Outcome Statement<br>➢ "…will take pictures of places, stores, volunteer places, jobs, community and people."<br>➢ "…will place pictures in a scrapbook."<br>◦ Fun Outcome Statement<br>➢ "…will arrange and invite family for a get together."<br>◦ *Individual #7 - TSS not found for the following Action Steps:* | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| policy. Additional documentation that is required to be maintained at the administrative office includes:<br>1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.<br><br>**Chapter 7 (CIHS) 3. Agency Requirements:**<br>**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.<br><br>**Chapter 11 (FL) 3. Agency Requirements:**<br>**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.<br><br>**Chapter 12 (SL) 3. Agency Requirements:**<br>**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.<br><br>**Chapter 13 (IMLS) 2. Service Requirements:**<br>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)<br>• Emergency contact information;<br>• Personal identification;<br>• ISP budget forms and budget prior authorization;<br>• ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan | ◦ Live Outcome Statement<br>➢ "…will research home items, price and purchase."<br>➢ "…will purchase one time use camera."<br>➢ "…will learn a new hobby and make items for her home."<br>◦ Work/learn Outcome Statement<br>➢ "…will research, inquire placement opportunities, and volunteer."<br>➢ "…will choose a job she enjoyed doing."<br>➢ "…will research and attend a variety of dance opportunities."<br>➢ "…will let staff know which dance style she likes."<br>◦ Fun Outcome Statement<br>➢ "…will research areas she would like to go to, plan and attend."<br>• Occupational Therapy Plan (#12) | | |

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| (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);<br>• 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;<br>• Copy of Guardianship or Power of Attorney documents as applicable;<br>• Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;<br>• Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable;<br>• Progress notes written by DSP and nurses;<br>• Signed secondary freedom of choice form;<br>• Transition Plan as applicable for change of provider in past twelve (12) months.<br><br>**DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012**<br>**III. Requirement Amendments(s) or Clarifications:**<br>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.<br><br>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. | | | |

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| Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007<br>**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:<br>(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;<br>(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);<br>(3) Progress notes and other service delivery documentation;<br>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;<br>(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;<br>(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 | | | |

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| (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.<br>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:<br>(a) Complete file for the past 12 months;<br>(b) ISP and quarterly reports from the current and prior ISP year;<br>(c) Intake information from original admission to services; and<br>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.<br><br>**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.<br><br>B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. | | | |

| Tag # 1A32 and LS14 / 6L14<br>Individual Service Plan Implementation | Standard Level Deficiency | | |
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| **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.<br><br>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. | 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 outcome and action plan for 7 of 17 individuals.<br><br>As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:<br><br>**Administrative Files Reviewed:**<br><br>**Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**<br><br>Individual #6<br>• According to the Fun Outcome; Action Step for "…will work on project until completed" is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2015.<br><br>Individual #14<br>• According to the Fun Outcome; Action Step for "…will research and select an outing" is to be completed 2 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2015.<br><br>• According to the Fun Outcome; Action Step for "…will invite a friend of her choice to participate in an outing" is to be completed 2 times per month, evidence found indicated it | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities.<br>[05/03/94; 01/15/97; Recompiled 10/31/01] | was not being completed at the required frequency as indicated in the ISP for 9/2015.<br><br>• According to the Fun Outcome; Action Step for "…participate in the outing" is to be completed 2 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2015.<br><br>Individual #17<br>• According to the Live Outcome; Action Step for "…will sort and put away her musical instruments" is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015 - 9/2015.<br><br>• According to the Fun Outcome; Action Step for "…research, invite a peer, and go on an outing of her choice with a peer of her choice" is to be completed 3 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015.<br><br>**Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**<br><br>Individual #1<br>• According to the Work/Learn Outcome; Action Step for "with staff assistance…will work in his garden" 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 10/2015.<br><br>Individual #5 | | |

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| | • According to the Work/Learn Outcome; Action Step for "…will participate in a self-soothing technique and decide whether or not he liked it" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015 - 10/2015.<br><br>Individual #14<br>According to the Work/Learn Outcome; Action Step for "…will volunteer" is to be completed 3 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015 - 10/2015.<br><br>Individual #15<br>According to the Work/Learn Outcome; Action Step for "…will research family history and heritage" is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 10/2015.<br><br>Individual #17<br>According to the Work/Learn Outcome; Action Step for "…will research and participate in a sensory stimulating activity" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015.<br><br>According to the Work/Learn Outcome; Action Step for "…will add her favorite sensory stimulating activity she learned about to her list" is to be completed 1 time per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015. | | |

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| | **Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**<br><br>Individual #9<br>• According to the Work/Learn Outcome; Action Step for "…will practice a new work skill" is to be completed 2 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015 - 9/2015.<br><br>**Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:**<br><br>Individual #9<br>• According to the Live Outcome; Action Step for "…will plan for, shop for, and prepare a crockpot meal" is to be completed 1 time per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2015 - 9/2015. | | |

| Tag # LS14 / 6L14<br>Residential Case File | Standard Level Deficiency | | |
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| Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013<br>**CHAPTER 11 (FL) 3. Agency Requirements**<br>**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.<br><br>**CHAPTER 12 (SL) 3. Agency Requirements**<br>**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.<br><br>**CHAPTER 13 (IMLS) 2. Service Requirements**<br>**B.1. Documents To Be Maintained In The Home:**<br>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;<br>b. Personal identification;<br>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;<br>d. Dated and signed consent to release information forms as applicable;<br>e. Current orders from health care practitioners;<br>f. Documentation and maintenance of accurate medical history in Therap website;<br>g. Medication Administration Records for the current month; | Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 6 of 15 Individuals receiving Supported Living Services.<br><br>Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:<br><br>• **ISP Teaching and Support Strategies**<br>◦ *Individual #2 - TSS not found for the following Action Steps:*<br>◦ Live Outcome Statement<br>➢ "…will use camera to take pictures of her chores she has in her home and use to create a home chore chart."<br>➢ "…will follow chart."<br>◦ Work Outcome Statement<br>➢ "…will create 4 different scripts for collection and appreciation."<br>➢ "…will create greeting cards for customers."<br>◦ Fun Outcome Statement<br>➢ "…will plan, arrange and invite family for a get together."<br>◦ *Individual #7 - TSS not found for the following Action Steps:*<br>◦ Live Outcome Statement<br>➢ "…will research home items, price and purchase."<br>➢ "…will purchase one time use camera." | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| h. Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided;<br>i. Progress notes written by DSP and nurses;<br>j. Documentation and data collection related to ISP implementation;<br>k. Medicaid card;<br>l. Salud membership card or Medicare card as applicable; and<br>m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable.<br><br>**DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012**<br>**III. Requirement Amendments(s) or Clarifications:**<br>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.<br><br>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.<br><br>***Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007***<br>**CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS**<br>**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 | ➢ "…will learn a new hobby and make items for her home."<br><br>◦ Work Outcome Statement<br>➢ "…will research and attend a variety of dance opportunities."<br><br>➢ "…will let staff know which dance style she likes."<br><br>◦ Fun Outcome Statement<br>➢ "…will research areas she would like to go, plan and attend."<br><br>• Positive Behavioral Plan (#5)<br><br>• Occupational Therapy Plan (#12)<br><br>• **Medical Emergency Response Plans**<br>◦ Aspiration (#14)<br>◦ Falls (#14)<br><br>• **Progress Notes written by DSP and/or Nurses regarding Health Status:**<br>◦ Individual #10 - None found for 11/1/2015. | | |

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| confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:<br>(1) Complete and current ISP and all supplemental plans specific to the individual;<br>(2) Complete and current Health Assessment Tool;<br>(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;<br><br>(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);<br><br>(5) Data collected to document ISP Action Plan implementation<br><br>(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;<br>(7) Physician's or qualified health care providers written orders;<br>(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s);<br>(9) Medication Administration Record (MAR) for the past three (3) months which includes:<br>(a) The name of the individual;<br>(b) A transcription of the healthcare practitioners prescription including the brand and generic name of the medication;<br>(c) Diagnosis for which the medication is prescribed; | | | |

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| (d) Dosage, frequency and method/route of delivery;<br>(e) Times and dates of delivery;<br>(f) Initials of person administering or assisting with medication; and<br>(g) An explanation of any medication irregularity, allergic reaction or adverse effect.<br>(h) For PRN medication an explanation for the use of the PRN must include:<br>(i) Observable signs/symptoms or circumstances in which the medication is to be used, and<br>(ii) Documentation of the effectiveness/result of the PRN delivered.<br>(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.<br>(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<br>(11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam. | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Date Due |
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| ***Service Domain: Qualified Providers –*** *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.* | | | |
| **Tag # 1A20**<br>**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:**<br>A. Individuals shall receive services from competent and qualified staff.<br>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.<br>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.<br>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.<br>E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines.<br>F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements.<br>G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. | Based on record review, the Agency did not ensure Orientation and Training requirements were met for 1 of 44 Direct Support Personnel.<br><br>Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed:<br><br>• Foundation for Health and Wellness (DSP #225) | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| 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.<br>H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001.<br>I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving service.<br><br>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013<br>**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.<br><br>**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;<br><br>**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 | | | |

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| DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy<br><br>**CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:**<br>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.<br><br>**CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:**<br>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 | | | |

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| 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.<br><br>**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<br>Agency Personnel Competency | Standard Level Deficiency | | |
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| **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.<br><br>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.<br><br>**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;<br><br>**CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training | Based on interview, the Agency did not ensure training competencies were met for 2 of 14 Direct Support Personnel.<br><br>**When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:**<br><br>• DSP #211 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #1)<br><br>**When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:**<br><br>• DSP #211 stated, "Don't know." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #1)<br><br>**When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:**<br><br>• DSP #200 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #4) | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.<br><br>**CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:**<br>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 | | | |

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| Documentation for DDSD Training Requirements.<br>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.<br><br>**CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:**<br>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 | | | |

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| Documentation for DDSD Training Requirements.<br>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.<br><br>**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 # 1A28.1<br>Incident Mgt. System - Personnel Training | Standard Level Deficiency | | |
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| **NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS**<br><br>**NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:**<br>**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.<br>**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. | Based on record review and interview, the Agency did not ensure Incident Management Training for 5 of 47 Agency Personnel.<br><br>**Direct Support Personnel (DSP):**<br>• Incident Management Training (Abuse, Neglect and Exploitation) (DSP# 209, 224, 234)<br><br>**When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect and Exploitation, the following was reported:**<br><br>• DSP #211 stated, "Don't know." Staff was not able to identify the State Agency as Division of Health Improvement.<br><br>**When DSP were asked to give examples of Exploitation, the following was reported:**<br><br>• DSP #200 stated, "Don't remember." | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| **C. Incident management system training curriculum requirements:**<br>**(1)** The community-based service provider shall conduct training or designate a knowledgeable representative to conduct training, in accordance with the written training curriculum provided electronically by the division that includes but is not limited to:<br>**(a)** an overview of the potential risk of abuse, neglect, or exploitation;<br>**(b)** informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;<br>**(c)** specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;<br>**(d)** specific instructions on how to respond to abuse, neglect, or exploitation;<br>**(e)** emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.<br>**(2)** All current employees and volunteers shall receive training within 90 days of the effective date of this rule.<br>**(3)** All new employees and volunteers shall receive training prior to providing services to consumers.<br>**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 | | | |

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| 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.<br><br>**Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II. POLICY STATEMENTS:**<br>A. Individuals shall receive services from competent and qualified staff.<br>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. | | | |

| Tag # 1A36<br>Service Coordination Requirements | Standard Level Deficiency | | |
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| **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:**<br>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:<br>1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency.<br>2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency.<br>3. Level I – must be completed within one (1) year of assignment to his/her position with the agency.<br><br>**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<br><br>**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 | Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 2 Service Coordinators.<br><br>Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed:<br><br>• Pre-Service Part One (SC #246)<br><br>• Pre-Service Part Two (SC #246)<br><br>• ISP Critique (SC #246 ) | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| provisions of the ISP, and shall report to the case manager on ISP implementation and the 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:<br><br>(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;<br>(ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations;<br>(iii) the designated service coordinator shall be familiar with and understand community service delivery and supports;<br>(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<br>Individual Specific Training | Standard Level Deficiency | | |
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| **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:**<br>A. Individuals shall receive services from competent and qualified staff.<br>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.<br><br>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.<br><br>**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;<br><br>**CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training | Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 2 of 47 Agency Personnel.<br><br>Review of personnel records found no evidence of the following:<br><br>**Direct Support Personnel (DSP):**<br><br>• Individual Specific Training (DSP #207, 238) | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training.<br><br>**CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:**<br>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 | | | |

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| Documentation for DDSD Training Requirements.<br>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.<br><br>**CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:**<br>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 | | | |

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| Documentation for DDSD Training Requirements.<br>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.<br><br>**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 |
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| ***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 # 1A27**<br>**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**<br><br>**NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:**<br><br>**A. Duty to report:**<br>**(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.<br>**(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.<br>**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.<br>**C. Initial reports, form of report, immediate action and safety planning, evidence** | 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 6 of 17 individuals.<br><br>Individual #1<br>• Incident date 12/17/2014. Allegation was Neglect/Exploitation. Incident report was received on 12/18/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." IMB late and failure report indicated incident of Exploitation was "Unconfirmed."<br><br>Individual # 4<br>• Incident date 11/16/2014. Allegation was Environmental Hazard. Incident report was received on 11/25/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed."<br><br>• Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 3/11/2015. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #5 | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| **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 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.<br>**(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 | • Incident date 11/14/2014. Allegation was Neglect. Incident report was received on 11/18/2015. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #9<br>• Incident date 12/18/2014. Allegation was Neglect. Incident report was received on 12/18/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."<br><br>• Incident date 2/26/2015. Allegation was Neglect. Incident report was received on 2/27/2015. IMB issued a Late Reporting for Neglect.<br><br>Individual #11<br>• Incident date 11/16/2014. Allegation was Environmental Hazard. Incident report was received on 11/25/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Unconfirmed."<br><br>• Incident date 00/00/0000. Allegation was Neglect. Incident report was received on 3/11/2015. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."<br><br>• Incident date 3/6/2015. Allegation was Neglect. Incident report was received on 3/11/2015. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."<br><br>Individual #15 | | |

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| 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.<br>**(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.<br>**(4) Immediate action and safety planning:** Upon discovery of any alleged incident of abuse, neglect, or exploitation, the community-based service provider shall:<br>**(a)** develop and implement an immediate action and safety plan for any potentially endangered consumers, if applicable;<br>**(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<br>**(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.<br>**(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 | • Incident date 12/17/2014. Allegation was Neglect. Incident report was received on 12/18/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed." | | |

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| 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.<br>**(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.<br>**(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.<br>**(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 # LS25 / 6L25<br>Residential Health and Safety (SL/FL) | Standard Level Deficiency | | |
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| 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:<br><br>a. Maintain basic utilities, i.e., gas, power, water and telephone;<br><br>b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;<br><br>c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;<br><br>d. Have a general-purpose first aid kit;<br><br>e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed;<br><br>f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; | Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 5 of 8 Supported Living residences.<br><br>Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:<br><br>**Supported Living Requirements:**<br><br>• Water temperature in home does not exceed safe temperature ($110^0$ F)<br>➢ Water temperature in home measured 123.0 $^0$ F (#4, 11, 12)<br><br>• 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, 8, 15, 17)<br><br>*Note: The following Individuals share a residence:*<br>➢ #2, 7, 17<br>➢ #3, 16<br>➢ #5, 12<br>➢ #1, 15<br>➢ #6, 10<br>➢ #4, 12<br>➢ #8<br>➢ #11 | **Provider:**<br>State your Plan of Correction for the deficiencies cited in this tag here: →<br><br>**Provider:**<br>Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: → | |

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| g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and<br><br>h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.<br><br>**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:<br><br>a. Maintain basic utilities, i.e., gas, power, water, and telephone;<br><br>b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;<br><br>c. Ensure water temperature in home does not exceed safe temperature ($110^0$ F) ; | | | |

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

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| 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.<br><br>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.<br><br>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.<br><br>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. | | | |

| Standard of Care | Deficiencies | Agency Plan of Correction, On-going QA/QI and Responsible Party | Date Due |
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***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 #1A12**
**All Services Reimbursement (No Deficiencies Found)**

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

**CHAPTER 5 (CIES) 6. REIMBURSEMENT** 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, nature of services, and length of a session of service billed.

1. 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 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; and
   c. The signature or authenticated name of staff providing the service.

**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.

**CHAPTER 7 (CIHS) 4. REIMBURSEMENT. A.** All Provider Agencies must maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the individual's name, date, time, Provider Agency name, nature of services and length of a session of service billed.

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.

**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.

1. 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;

Billing for ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports) services was reviewed for 17 of 17 individuals. *Progress notes and billing records supported billing activities for the months of August, September and October 2015.*

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| Date: | February 29, 2016 |
| To: | Melinda Golden, Interim Chief Executive Officer |
| Provider: | Tohatchi Area of Opportunity & Services, Inc. |
| Address: | 1658 S. 2nd Street |
| State/Zip: | Gallup, New Mexico 87301 |
| E-mail Address: | mgolden777@yahoo.com |
| Region: | Northwest |
| Survey Date: | November 16 - 19, 2016 |
| Program Surveyed: | Developmental Disabilities Waiver |
| Service Surveyed: | ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services); *Other* (Customized In-Home Supports) |
| Survey Type: | Routine |

Dear Ms. Golden:

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

**The Plan of Correction process is now complete.**

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

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