

Date: May 22, 2015

To: Deb Battista, Chief Executive Officer

Provider: Tresco, Inc.,
Address: 1700 Copper Loop

State/Zip: Las Cruces, New Mexico 88005

E-mail Address: dbattista@trescoinc.org

CC: Larry Dorbandt, Board Chair

Board Chair

E-Mail Address <u>Idorbandt@zianet.com</u>

Region: Southwest

Survey Date: March 9 – 12, 2014

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: 2012: Living Supports (Supported Living): Inclusion Supports (Customized Community

Supports, Community Integrated Employment Services) and Other (Customized In-Home

Supports)

2007: Community Living (Supported Living) and Community Inclusion (Adult Habilitation,

Supported Employment)

Survey Type: Routine

Team Leader: Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management

Bureau

Team Members: Corrina Strain, RN, BSN, Healthcare Surveyor, Division of Health Improvement/Quality

Management Bureau; Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Improvement/Quality Management Bureau; Jesus Trujillo, RN, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Amanda Castaneda. MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Richard Reyes, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Russell Cain, BSW, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Stephanie Roybal, BA. Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Tony Fragua, Program Manager, Division of Health Improvement/Quality

Management Bureau

Dear Ms. Battista;

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.

DIVISION OF HEALTH IMPROVEMENT

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

Determination of Compliance:

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

Partial Compliance with Conditions of Participation

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

- Tag # 1A32 and LS14/6L14 Individual Service Plan Implementation
- Tag # 1A37 Individual Specific Training

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

Plan of Correction:

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

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:

- Quality Management Bureau, Attention: Plan of Correction Coordinator 5301 Central Ave. NE Suite 400 Albuquerque, NM 87108
- 2. Developmental Disabilities Supports Division Regional Office for region of service surveyed

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

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

Request for Informal Reconsideration of Findings (IRF):

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

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

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

Please call the Plan of Correction Coordinator Anthony Fragua at 505-231-7436 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell, BS

Deb Russell, BS Team Lead/Healthcare Surveyor Division of Health Improvement Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: March 9, 2015

Present: <u>Tresco, Inc.</u>

Deb Battista, Chief Executive Officer
Julia Harrison, Quality Assurance Manager

Julia Harrison, Quality Assurance Manage

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor Crystal Lopez-Beck, BA, Deputy Bureau Chief Amanda Castaneda, MPA, Healthcare Surveyor Russell Cain, BSW, Healthcare Surveyor Florence Mulheron, BA, Healthcare Surveyor

Exit Conference Date: March 12, 2015

Present: Tresco, Inc.

Deb Battista, Chief Executive Officer
Julia Harrison, Quality Assurance Manager
Maureen Gant, Program Services Manager

Maggie Rodriguez, Program Services Records Supervisor

Laura Miller, Vice President Program Service Steve Adams, Assistant Adult Services Manager Jessica Milliken, Quality Assurance Specialist

DOH/DHI/QMB

Deb Russell, BS, Team Lead/Healthcare Surveyor Amanda Castaneda, MPA, Healthcare Surveyor Russell Cain, BSW, Healthcare Surveyor Florence Mulheron, BA, Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor Jesus Trujillo, RN, Healthcare Surveyor Richard Reyes, BA Healthcare Surveyor

DDSD - Southwest Regional Office

Jeana Caruthers, Southwest Regional Director

Administrative Locations Visited Number: 1

Total Sample Size Number: 26

9 - Jackson Class Members 17 - Non-Jackson Class Members

16 - Supported Living

14 - Customized Community Supports

16 - Community Integrated Employment Services

6 - Adult Habilitation

6 - Supported Employment

7 - Customized In-Home Supports

Total Homes Visited Number: 11

❖ Supported Living Homes Visited Number: 11

Note: The following Individuals share a residence:

> #10, 13 > #7, 14, 16 > #12, 22 > #6, 21

Persons Served Records Reviewed Number: 26

Persons Served Interviewed Number: 15

Persons Served Observed Number: 11 (3 Individuals did not respond to surveyor

questions; 5 Individuals chose not to be interviewed; 3 Individuals were not available during on-site survey)

Direct Support Personnel Interviewed Number: 34

Direct Support Personnel Records Reviewed Number: 187

Substitute Care/Respite Personnel

Records Reviewed Number: 14

Service Coordinator Records Reviewed Number: 6

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
 - o 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
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement

DOH - Developmental Disabilities Supports Division

DOH - Office of Internal Audit
HSD - Medical Assistance Division

Attachment A

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

Introduction:

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

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

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

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

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 505-231-7436 or email at Anthony.Fragua@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

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

Instructions for Completing Agency POC:

Required Content

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

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

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

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

- sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
- 5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
- 6. The POC must be signed and dated by the agency director or other authorized official.

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

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

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

Completion Dates

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

Initial Submission of the Plan of Correction Requirements

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

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

POC Document Submission Requirements

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

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

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

Attachment B

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

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

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

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

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

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

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

Conditions of Participation (CoPs)

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

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

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

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

Service Domain: Level of Care

Condition of Participation:

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

Service Domain: Plan of Care

Condition of Participation:

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

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Plan of Care

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

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

Attachment C

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

Introduction:

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

Instructions:

- The Informal Reconsideration of the Finding (IRF) request must be received in writing to the QMB Deputy Bureau Chief <u>within 10 business days</u> 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: Tresco, Inc. - Southwest 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)

2007: Community Living (Supported Living) and Community Inclusion (Adult Habilitation, Supported

Employment)

Monitoring Type: Routine Survey

Survey Date: March 9 – 12, 2015

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Service Domain: Service Plans: ISP Im	plementation - Services are delivered in a	accordance with the service plan, including	type,
scope, amount, duration and frequency s	pecified in the service plan.		
Tag # 1A08	Standard Level Deficiency		
Agency Case File	•		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments that are of quality and contain content acceptable to DVR and DDSD; 2. Career Development Plans as incorporated in the ISP; and 3. Documentation of evidence that services provided under the DDW are not otherwise available under the Rehabilitation Act of 1973 (DVR). Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 13 of 26 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Current Emergency and Personal Identification Information ° Did not contain Pharmacy Information (#5) • ISP Teaching and Support Strategies ° Individual #1 - TSS not found for the following Action Steps: ° Work/Learn Outcome Statement > "Will pick an activity." ° Fun/relationships Outcome Statement > "Will work with staff and plan the trip."	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

comply with the DDSD Individual Case File Matrix policy. Additional documentation that is required to be maintained at the administrative office includes:

 Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.

Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.

Chapter 11 (FL) 3. Agency Requirements:
D. Consumer Records Policy: All Family Living
Provider Agencies must maintain at the
administrative office a confidential case file for
each individual. Provider agency case files for
individuals are required to comply with the DDSD
Individual Case File Matrix policy.

Chapter 12 (SL) 3. Agency Requirements:
D. Consumer Records Policy: All Living
Supports- Supported Living Provider Agencies
must maintain at the administrative office a
confidential case file for each individual. Provider
agency case files for individuals are required to
comply with the DDSD Individual Case File Matrix
policy.

Chapter 13 (IMLS) 2. Service Requirements:

- C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)
- Emergency contact information;
- · Personal identification;
- · ISP budget forms and budget prior authorization;
- ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan

- Individual #3 TSS not found for the following Action Steps:
- Live Outcome Statement
 - "Will purchase and use beauty products for 1 year."
 - "Will train and support staff how to assist individual with purchase and choice making of products."
- Individual #5 TSS not found for the following Action Steps:
- Fun/relationship Outcome Statement"Will choose a group activity to join."
- Individual #8 TSS not found for the following Action Steps:
- Work/learn Outcome Statement"Will attend DVR appointments."
 - > "Job search."
- Individual #11 TSS not found for the following Action Steps:
- Live Outcome Statement
 - "Will fill med pill box with staff supervision."
 - "Will take medication after a reminder phone call/alert from his electronic caregiver."
- Individual #13 TSS not found for the following Action Steps:
- Live Outcome Statement
 - "Water and maintain productive plants."
- Work/learn Outcome Statement
 - "Participate in 2 group activities a week to socialize"

- (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI);
- Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay;
- Copy of Guardianship or Power of Attorney documents as applicable;
- Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays;
- Written consent by relevant health decision maker and primary care practitioner for selfadministration of medication or assistance with medication from DSP as applicable;
- Progress notes written by DSP and nurses;
- Signed secondary freedom of choice form;
- Transition Plan as applicable for change of provider in past twelve (12) months.

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:

A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

- ° Fun/relationship Outcome Statement
 - "Participate in at least 2 social activities outside of home and Adult Habilitation."
- Individual #15 TSS not found for the following Action Steps:
- Live Outcome Statement
 - > "Will save at least \$5.00 toward a pet."
- ° Fun/relationship Outcome Statement
 - > "Will select restaurant of her choice."
- Individual #16 TSS not found for the following Action Steps:
- Live Outcome Statement
 - "Choose a relaxing activity."
- Work/learn Outcome Statement
 - "Select, choose site and volunteer."
- ° Fun/relationship Outcome Statement
 - > "Develop pictures and work on collage."
- Individual #17 TSS not found for the following Action Steps:
- ° Work/learn Outcome Statement
 - "Will complete her task list."
- o Individual #26 TSS not found for the following Action Steps:
- Work/learn Outcome Statement
- "Will take over a new task."
- "Will state the activity for staff to write for her to copy (at least 2 sentences)."
- Documentation of Guardianship/Power of Attorney (#20)

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007

CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:

- (1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;
- (2) The individual's complete and current ISP, with all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);
- (3) Progress notes and other service delivery documentation;
- (4) Crisis Prevention/Intervention Plans, if there are any for the individual;
- (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;
- (6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and
- (7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.

• Annual Physical (#20)

Dental Exam

- Individual #2 As indicated by collateral documentation reviewed, the exam was completed on 5/31/2014. No evidence of exam results was found.
- Individual #24 As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found.

Vision Exam

- Individual #2 As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.
- Individual #20 As indicated by collateral documentation reviewed, exam was completed on 9/17/2012. Follow-up was to be completed in 2 years. No evidence of follow-up found.

Blood Levels

 Individual #2 - As indicated by collateral documentation reviewed, lab work was ordered on 1/27/2015. No evidence of lab results were found.

Endoscopy

 Individual #2 - As indicated by collateral documentation reviewed, lab work was ordered on 1/27/2015. No evidence of lab results were found.

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

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Condition of Participation Level Deficiency		
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
ISP for each stated desired outcomes and action plan.	Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the		
C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining	ISP for each stated desired outcomes and action plan for 13 of 26 individuals.		
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,	As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes:		
revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's	Administrative Files Reviewed: Supported Living Data Collection/Data	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag	
future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on	Tracking/Progress with regards to ISP Outcomes:	number here: →	
the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental	 Individual #1 None found regarding: Fun Outcome/Action Step: "Will need to deposit at least \$50 a 		
disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by	month into a travel account" for 12/2014. Individual #3		
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	 None found regarding: Live Outcome/Action Step: "Will purchase and use beauty products" for 12/2014 – 1/2015. 		
current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as	Individual #5 • According to the Live Outcome; Action Step for "Will work on putting the car together" is		
determined by the IDT and documented in the ISP.	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 1/2015.		

D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]

Individual #10

 According to the Live Outcome; Action Step for Will get together with roommates to plan what activities to do and when to do them" 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 2/2015.

Individual #12

- According to the Fun Outcome; Action Step for "Research and plan trips" 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 12/2014 – 1/2015.
- None found regarding: Fun Outcome/Action Step: "Research and plan trips" for 2/2015.

Individual #22

 According to the Live Outcome; Action Step for "Will make choice to plan her event" 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 12/2014 – 2/2015.

Customized In Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #4

None found regarding: Work/learn
 Outcome/Action Step: "Will be prepared and ready for work" for 12/2014 – 2/2015.

 None found regarding: Fun Outcome/Action Step: "Will work on an art project" for 12/2014 – 2/2015.

Individual #9

- None found regarding: Live Outcome/Action Step: "Will pay his utility bills" for 1/2015.
- None found regarding: Live Outcome/Action Step: "Will reconcile and balance his account" for 12/2014 – 2/2015.

Individual #11

- None found regarding: Live Outcome/Action Step: "Will fill his medication pill box with staff supervision" for 12/2014 – 2/2015.
- None found regarding: Live Outcome/Action Step: "Will take medication with staff checking afterwards" for 12/2014 2/2015.

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

- According to the Fun Outcome; Action Step for "Will choose a group activity to join" 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 1/2015 – 2/2015.
- According to the Fun Outcome; Action Step for "Will participate with others in the activity without incidents" 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 1/2015 – 2/2015.

Individual #8

- According to the Work/learn Outcome; Action Step for Will research and create a visual presentation" 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 12/2014 – 2/2015.
- None found regarding: Work/learn Outcome/Action Step: "Will attend DVR appointments" for 12/2014 – 2/2015.
- None found regarding: Work/learn
 Outcome/Action Step: "Will job search" for
 12/2014 2/2015.

Individual #9

- None found regarding: Fun Outcome/Action Step: "Will attend photo class" for 12/2014 – 2/2015.
- None found regarding: Fun Outcome/Action Step: "Will develop his photographs and include in his photo album to share with family and friends" for 12/2014 – 2/2015.

- According to the Fun Outcome; Action Step for "Will announce attend and participate in assisting with the Zumba class" 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 1/2015 – 2/2015.
- According to the Fun Outcome; Action Step for "Will get the Zumba DVD and play it on the computer without verbal prompts" 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 1/2015 - 2/2015.

Individual #11

 None found regarding: Fun Outcome/Action Step: "Will participate in physical activity" for 12/2014 – 2/2015.

Individual #12

 No Outcomes or DDSD exemption/decision justification found for Customized Community Supports Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."

Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #1

 None found regarding: Work/learn Outcome/Action Step: "Will pick an activity." for 12/2014 – 2/2015

- According to the Fun Outcome; Action Step for "Will take pictures of friends, activities and events at AH" 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 12/2014 – 1/2015.
- According to the Fun Outcome; Action Step for Will up load the pictures into the computer" 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 12/2014 – 2/2015.

Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

Individual #9

 None found regarding: Work/learn Outcome/Action Step: "Will meet with his supervisor to discuss any issues/problems" for 12/2014 – 2/2015.

Individual #19

None found regarding: Work/learn
 Outcome/Action Step: "Will dress in my
 clean uniform each day I work" for 12/2014
 – 2/2015.

Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:

- None found regarding: Work/learn
 Outcome/Action Step: "Will be available to
 work with supported employment staff" for
 12/2014.
- None found regarding: Work/learn
 Outcome/Action Step: "Will be available to
 Discovery Project staff" for 12/2014.
- None found regarding: Work/learn Outcome/Action Step: "Will work on his computer and attend computer class" for 12/2014.

Residential Files Reviewed:	
Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:	
Individual #18 • None found regarding: Live Outcome/Action Step: "Will choose chore to complete from chore list" for 3/1 – 6, 2015. Action Step is to be implemented 2 times per week.	
 Individual #26 According to the Live Outcome; Actions Steps for "Will develop and practice hone skills" is to be completed 3 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 3/1 – 6, 2015. 	

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 11 (FL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 11 of 16 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current:	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
CHAPTER 12 (SL) 3. Agency Requirements C. Residence Case File: The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy.	 Current Emergency and Personal Identification Information Did not contain Pharmacy Information (#6, 21) Did not contain Individual's current address (#10, 12) 	Provider:	
CHAPTER 13 (IMLS) 2. Service Requirements B.1. Documents To Be Maintained In The Home: a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access;	 Did not contain Names and Phone Numbers of Relatives, or Guardian or Conservator Information (#19) Did not contain Health Plan Information (#6, 21) 	Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
 b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, 	 Annual ISP (#16) Individual Specific Training Section of ISP (formerly Addendum B) (#16) 		
MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable;	ISP Teaching and Support Strategies Individual #13- TSS not found for the following Action Steps:		
 d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website; 	 Live Outcome Statement "Will water and maintain productive plants." 		
g. Medication Administration Records for the current month; h. Record of medical and dental appointments for the current year, or during the period of stay for	 Individual #15 - TSS not found for the following Action Steps: Live Outcome Statement "Will save at least \$5 toward a pet" 		

- short term stays, including any treatment provided:
- i. Progress notes written by DSP and nurses;
- j. Documentation and data collection related to ISP implementation;
- k. Medicaid card;
- I. Salud membership card or Medicare card as applicable; and
- m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable.

DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:

A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS

A. Residence Case File: For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following:

- Individual #16 TSS not found for the following Action Steps:
- ° Live Outcome Statement
 - "Choose relaxing activity"
- Individual #19 TSS not found for the following Action Steps:
- Work/learn Outcome Statement
 - "Will leave my house to catch the bus for work"
 - "Will leave my house to catch busses to Tresco for day service activities"
- Individual #26 TSS not found for the following Action Steps:
- ° Relationships/Fun Outcome Statement
 - "Will make a call to plan/confirm social club activity"
- Positive Behavioral Plan (#15, 16, 21)
- Behavior Crisis Intervention Plan (#15, 16, 26)
- Speech Therapy Plan (#21)
- Physical Therapy Plan (#21)
- Healthcare Passport (#15, 19, 23)

• Special Health Care Needs

- ° Nutritional Plan (#14, 18)
- ° Daily Oral Care Supports (#23)
- Comprehensive Aspiration Risk Management Plan:
- Not Current (#15, 19, 21)

• Health Care Plans

° Status of Oral Care/Hygiene (#26)

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

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

Tag # IH17 Reporting Requirements	Standard Level Deficiency		
(Customized In-Home Supports Reports)	•		
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 7 (CIHS) 3. Agency Requirements: F. Customized In-Home Supports Provider	Based on record review, the Agency did not complete written status reports for 1 of 7 individuals receiving Customized In-Home Supports. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: Customized In-Home Supports Semi-Annual Reports: Individual #25 – None found for 5/2014 – 10/2014 (ISP term 11/1/2013 – 10/31/2014)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
Agency Reporting Requirements: 1. Semi-Annual Reports: Customized In-Home			
Supports providers must submit written semi- annual status reports to the individual's Case Manager and other IDT members no later than one hundred ninety (190) calendar days after the ISP effective date and fourteen (14) calendar days prior to the annual ISP meeting. When reports are developed in any language other than English, it is the responsibility of the provider to translate the			

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
		ified providers to assure adherence to waive rovider training is conducted in accordance	
Tag # 1A11.1 Transportation Training	Standard Level Deficiency	Duccidon	
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Training Requirements for Direct Service Agency Staff Policy Eff. Date: March 1, 2007 II. POLICY STATEMENTS: I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment and before working alone with an individual receiving services. The training shall address at least the following: 1. Operating a fire extinguisher 2. Proper lifting procedures 3. General vehicle safety precautions (e.g., pre- trip inspection, removing keys from the ignition when not in the driver's seat) 4. Assisting passengers with cognitive and/or physical impairments (e.g., general guidelines for supporting individuals who may be unaware of safety issues involving traffic or those who require physical assistance to enter/exit a vehicle) 5. Operating wheelchair lifts (if applicable to the staff's role) 6. Wheelchair tie-down procedures (if applicable to the staff's role) 7. Emergency and evacuation procedures (e.g., roadside emergency, fire emergency) NMAC 7.9.2 F. TRANSPORTATION: (1) Any employee or agent of a regulated facility or agency who is responsible for assisting a resident in boarding or alighting from a motor vehicle must complete a state-approved training	Based on record review, the Agency did not provide and/or have documentation for staff training regarding the safe operation of the vehicle, assisting passengers and safe lifting procedures for 3 of 187 Direct Support Personnel. No documented evidence was found of the following required training: Transportation (DSP #319, 321, 370)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

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

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

personal support staff [Policy T-003: for Training

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

Tag # 1A20	Standard Level Deficiency		
Direct Support Personnel Training	•		
Department of Health (DOH) Developmental	Based on record review, the Agency did not	Provider:	
Disabilities Supports Division (DDSD) Policy -	ensure Orientation and Training requirements	State your Plan of Correction for the	
Policy Title: Training Requirements for Direct	were met for 4 of 187 Direct Support Personnel.	deficiencies cited in this tag here: →	
Service Agency Staff Policy - Eff. March 1, 2007		3	
- II. POLICY STATEMENTS:	Review of Direct Support Personnel training		
A. Individuals shall receive services from	records found no evidence of the following		
competent and qualified staff.	required DOH/DDSD trainings and certification		
B. Staff shall complete individual-specific (formerly	being completed:		
known as "Addendum B") training requirements in	boing completed.		
accordance with the specifications described in the	• First Aid (DSP #298, 369)		
individual service plan (ISP) of each individual	• Filst Ald (DSP #290, 309)		
served.	ODD (DOD #000 000 000)		
C. Staff shall complete training on DOH-approved	• CPR (DSP #229, 298, 369)		
incident reporting procedures in accordance with 7			
NMAC 1.13.	Assisting With Medication Delivery (DSP)	Dunadalan	
D. Staff providing direct services shall complete	#209, 298)	Provider:	
training in universal precautions on an annual		Enter your ongoing Quality Assurance/Quality	
basis. The training materials shall meet		Improvement processes as it related to this tag	
Occupational Safety and Health Administration		number here: →	
(OSHA) requirements.			
E. Staff providing direct services shall maintain			
certification in first aid and CPR. The training			
materials shall meet OSHA			
requirements/guidelines.			
F. Staff who may be exposed to hazardous			
chemicals shall complete relevant training in			
accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved			
behavioral intervention system (e.g., Mandt, CPI)			
before using physical restraint techniques. Staff			
members providing direct services shall maintain			
certification in a DDSD-approved behavioral			
intervention system if an individual they support			
has a behavioral crisis plan that includes the use of			
physical restraint techniques.			
H. Staff shall complete and maintain certification in			
a DDSD-approved medication course in			
accordance with the DDSD Medication Delivery			
Policy M-001.			
Staff providing direct services shall complete			
safety training within the first thirty (30) days of			

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

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

Tag # 1A22	Standard Level Deficiency		
Agency Personnel Competency	Standard Lover Demoising		
Department of Health (DOH) Developmental	Based on interview, the Agency did not ensure	Provider:	
Disabilities Supports Division (DDSD) Policy	training competencies were met for 6 of 34	State your Plan of Correction for the	
- Policy Title: Training Requirements for	Direct Support Personnel.	deficiencies cited in this tag here: →	
Direct Service Agency Staff Policy - Eff.	Briode Support Fordormon	denote the death and tag hore.	
March 1, 2007 - II. POLICY STATEMENTS:	When DSP were asked if the Individual had a		
A. Individuals shall receive services from	Positive Behavioral Supports Plan and if so,		
competent and qualified staff.	what the plan covered, the following was		
B. Staff shall complete individual specific	reported:		
(formerly known as "Addendum B") training	·		
requirements in accordance with the	DSP #282 stated, "Hasn't had any		
specifications described in the individual service	behaviors." According to the Individual		
plan (ISP) for each individual serviced.	Specific Training Section of the ISP, the		
	Individual requires a Positive Behavioral		
Developmental Disabilities (DD) Waiver Service	Supports Plan. (Individual #18)		
Standards effective 11/1/2012 revised 4/23/2013		Provider:	
CHAPTER 5 (CIES) 3. Agency Requirements	When DSP were asked if the Individual had	Enter your ongoing Quality Assurance/Quality	
G. Training Requirements: 1. All Community	an Occupational Therapy Plan and if so, what	Improvement processes as it related to this tag	
Inclusion Providers must provide staff training in	the plan covered, the following was reported:	number here: →	
accordance with the DDSD policy T-003:			
Training Requirements for Direct Service	DSP #282 stated, "No." According to the		
Agency Staff Policy. 3. Ensure direct service	Individual Specific Training Section of the		
personnel receives Individual Specific Training	ISP, the Individual requires an Occupational		
as outlined in each individual ISP, including	Therapy Plan. (Individual #18)		
aspects of support plans (healthcare and behavioral) or WDSI that pertain to the	When DCD ware calcad if the Individual had a		
employment environment.	When DSP were asked if the Individual had a		
employment environment.	Physical Therapy Plan and if so, what the plan covered, the following was reported:		
CHAPTER 6 (CCS) 3. Agency Requirements	pian covered, the following was reported:		
F. Meet all training requirements as follows:	DSP #282 stated, "No." According to the		
All Customized Community Supports	Individual Specific Training Section of the		
Providers shall provide staff training in	ISP, the Individual requires a Physical		
accordance with the DDSD Policy T-003:	Therapy Plan. (Individual #18)		
Training Requirements for Direct Service			
Agency Staff Policy;	When DSP were asked if the Individual had		
	Health Care Plans and if so, what the plan(s)		
CHAPTER 7 (CIHS) 3. Agency Requirements	covered, the following was reported:		
C. Training Requirements: The Provider			
Agency must report required personnel training			

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

CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:

A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and

 DSP #201 stated, "I don't think he has Health Care Plans." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index and Constipation. (Individual #23)

When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:

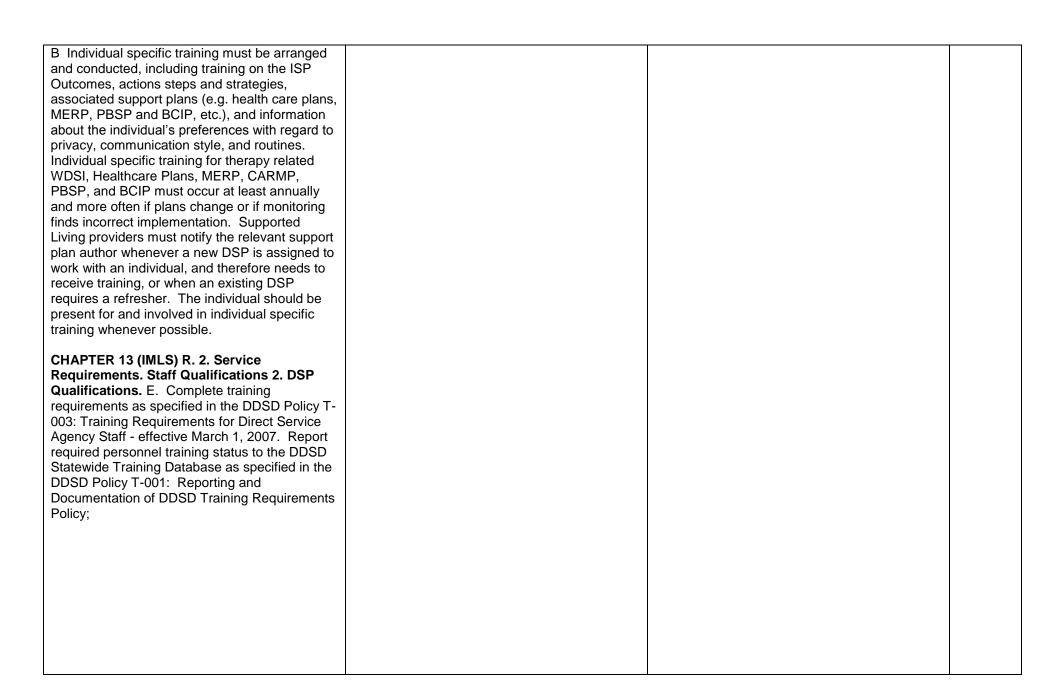
- DSP #240 stated, "Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Falls. (Individual #3)
- DSP #377 stated, "No MERPs. No he doesn't have any." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Respiratory. (Individual #6)
- DSP #308 stated, "Constipation." The Individual Specific Training section of the ISP indicates the Individual requires a crisis plan for Aspiration: fast eating-choking. (Individual #14)

When DSP were asked what are the signs of high blood sugar, the following was reported:

 DSP #280 stated, "She may panic. I've never had to deal with that." As indicated by the Individual Specific Training section of the ISP residential and day DSP, require training on Diabetes.

Documentation for DDSD Training		
Requirements.		
B. Individual specific training must be arranged		
and conducted, including training on the		
Individual Service Plan outcomes, actions steps		
and strategies and associated support plans		
(e.g. health care plans, MERP, PBSP and BCIP		
etc.), information about the individual's		
preferences with regard to privacy,		
communication style, and routines. Individual		
specific training for therapy related WDSI,		
Healthcare Plans, MERPs, CARMP, PBSP, and		
BCIP must occur at least annually and more		
often if plans change or if monitoring finds		
incorrect implementation. Family Living		
providers must notify the relevant support plan		
author whenever a new DSP is assigned to work		
with an individual, and therefore needs to		
receive training, or when an existing DSP		
requires a refresher. The individual should be		
present for and involved in individual specific		
training whenever possible.		
CHAPTER 12 (SL) 3. Agency Requirements		
B. Living Supports- Supported Living		
Services Provider Agency Staffing		
Requirements: 3. Training:		
A. All Living Supports- Supported Living		
Provider Agencies must ensure staff training in		
accordance with the DDSD Policy T-003: for		
Training Requirements for Direct Service		
Agency Staff. Pursuant to CMS requirements,		
the services that a provider renders may only be claimed for federal match if the provider has		
completed all necessary training required by the		
state. All Supported Living provider agencies		
must report required personnel training status to		
the DDSD Statewide Training Database as		
specified in DDSD Policy T-001: Reporting and		
Documentation for DDSD Training		
2004. Total and 101 101 1000 Training		

Requirements.



Tag # 1A28.1	Standard Level Deficiency		
Incident Mgt. System - Personnel	Clandard Ecver Beneficiery		
Training			
	Donal on manual antique and interview the	Danidan	
NMAC 7.1.14 ABUSE, NEGLECT,	Based on record review and interview, the	Provider:	
EXPLOITATION, AND DEATH REPORTING,	Agency did not ensure Incident Management	State your Plan of Correction for the	
TRAINING AND RELATED REQUIREMENTS	Training for 8 of 193 Agency Personnel.	deficiencies cited in this tag here: →	
FOR COMMUNITY PROVIDERS			
	Direct Support Personnel (DSP):		
NMAC 7.1.14.9 INCIDENT MANAGEMENT	 Incident Management Training (Abuse, 		
SYSTEM REQUIREMENTS:	Neglect and Exploitation) (DSP# 202, 223,		
A. General: All community-based service	276, 298, 375, 382, 384)		
providers shall establish and maintain an incident			
management system, which emphasizes the	When Direct Support Personnel were asked		
principles of prevention and staff involvement.	what State Agency must be contacted when		
The community-based service provider shall	there is suspected Abuse, Neglect and		
ensure that the incident management system	Exploitation, the following was reported:		
policies and procedures requires all employees			
and volunteers to be competently trained to	 DSP #283 stated, "I have the number but 	Provider:	
respond to, report, and preserve evidence related	can't remember the agency." Staff was not	Enter your ongoing Quality Assurance/Quality	
to incidents in a timely and accurate manner.	able to identify the State Agency as Division	Improvement processes as it related to this tag	
B. Training curriculum: Prior to an employee or	of Health Improvement.	number here: →	
volunteer's initial work with the community-based			
service provider, all employees and volunteers			
shall be trained on an applicable written training			
curriculum including incident policies and			
procedures for identification, and timely reporting			
of abuse, neglect, exploitation, suspicious injury,			
and all deaths as required in Subsection A of			
7.1.14.8 NMAC. The trainings shall be reviewed			
at annual, not to exceed 12-month intervals. The			
training curriculum as set forth in Subsection C of			
7.1.14.9 NMAC may include computer-based			
training. Periodic reviews shall include, at a			
minimum, review of the written training curriculum			
and site-specific issues pertaining to the			
community-based service provider's facility.			
Training shall be conducted in a language that is			
understood by the employee or volunteer.			
C. Incident management system training			
curriculum requirements:			

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

curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be

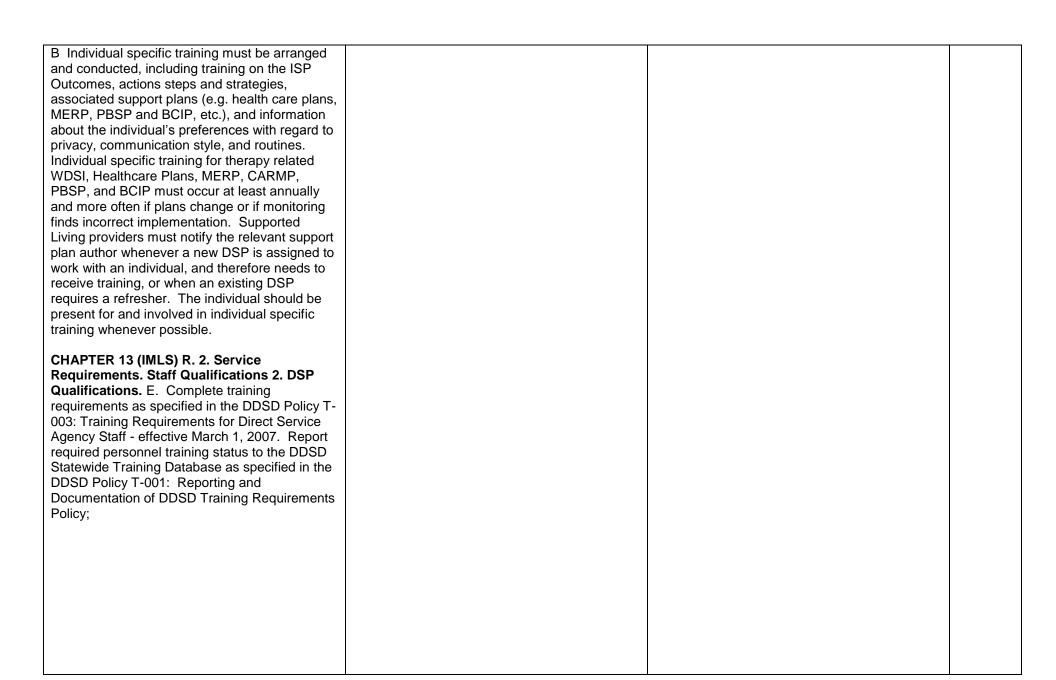
made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.		
Policy Title: Training Requirements for Direct Service Agency Staff Policy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

Tag # 1A37	Condition of Participation Level		
Individual Specific Training	Deficiency		
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 72 of 193 Agency Personnel. Review of personnel records found no evidence of the following: Direct Support Personnel (DSP): Individual Specific Training (DSP #200, 201, 204, 207, 208, 213, 214, 216, 223, 224, 225, 228, 229, 230, 232, 236, 238, 241, 242, 244, 246, 249, 251, 252, 255, 259, 262, 267, 268, 270, 272, 274, 276, 277, 282, 286, 288, 289, 292, 294, 296, 297, 298, 300, 301, 302, 303, 307, 311, 315, 316, 317, 318, 319, 320, 326, 330, 332, 334, 336, 338, 348, 352, 353, 354, 356, 357, 362, 363, 364, 375) Service Coordination Personnel (SC): Individual Specific Training (SC #391)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	
Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training			

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

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

Requirements.



Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
	The state, on an ongoing basis, identifies,	•	
,	ıals shall be afforded their basic human righ	its. The provider supports individuals to ac	cess
needed healthcare services in a timely n			
Tag # 1A09	Standard Level Deficiency		
Medication Delivery			
Routine Medication Administration			
NMAC 16.19.11.8 MINIMUM STANDARDS:	Medication Administration Records (MAR) were	Provider:	
A. MINIMUM STANDARDS FOR THE	reviewed for the months of February and March	State your Plan of Correction for the	
DISTRIBUTION, STORAGE, HANDLING AND	2015.	deficiencies cited in this tag here: →	
RECORD KEEPING OF DRUGS:			
(d) The facility shall have a Medication	Based on record review 3 of 16 individuals had		
Administration Record (MAR) documenting	Medication Administration Records (MAR),		
medication administered to residents, including over-the-counter medications.	which contained missing medications entries and/or other errors:		
This documentation shall include:	and/or other errors.		
(i) Name of resident;	Individual #6		
(ii) Date given;	March 2015		
(iii) Drug product name;	Medication Administration Records contained		
(iv) Dosage and form;	missing entries. No documentation found		
(v) Strength of drug;	indicating reason for missing entries:		
(vi) Route of administration;	 Lamotrigine 100mg (1 time daily) – Blank 	Provider:	
(vii) How often medication is to be taken;	3/3, 4, 5 (7:00 AM)	Enter your ongoing Quality Assurance/Quality	
(viii) Time taken and staff initials;		Improvement processes as it related to this tag	
(ix) Dates when the medication is	 Lamotrigine 25mg (1 time daily) – Blank 3/8 	number here: →	
discontinued or changed;	(4:00 PM)		
(x) The name and initials of all staff			
administering medications.	• Melatonin 5mg (1 time daily) – Blank 3/2, 3,		
Model Custodial Procedure Manual	4 (7:00 PM)		
D. Administration of Drugs	N (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Unless otherwise stated by practitioner,	Methyphenidate 10mg (2 times daily) – Plants 2/9 (4:00 PM)		
patients will not be allowed to administer their	Blank 3/8 (4:00 PM)		
own medications.	Ziprasidone 80mg (2 times daily) – Blank		
Document the practitioner's order authorizing	3/5, 9 (7:00 AM)		
the self-administration of medications.	5/5, 3 (1.00 AWI)		
	Individual #18		
	March 2015		

All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include:

- symptoms that indicate the use of the medication,
- exact dosage to be used, and
- the exact amount to be used in a 24 hour period.

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8. Providing assistance with medication delivery as outlined in the ISP; C. Individual Community Integrated Employment 3. Providing assistance with medication delivery as outlined in the ISP; D. Group Community Integrated Employment 4. Providing assistance with medication delivery as outlined in the ISP; and

B. Community Integrated Employment Agency Staffing Requirements: o. Comply with DDSD Medication Assessment and Delivery Policy and Procedures;

CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community
Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. C. Small Group Customized Community
Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. D. Group Customized Community Supports 19. Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy.

CHAPTER 11 (FL) 1 SCOPE OF SERVICES

Medication Administration Records did not contain the strength of the medication which is to be given:

- Acidiphilus Caplet (1 time daily)
- Therems-M Tablet (1 time daily)

Individual #21 March 2015

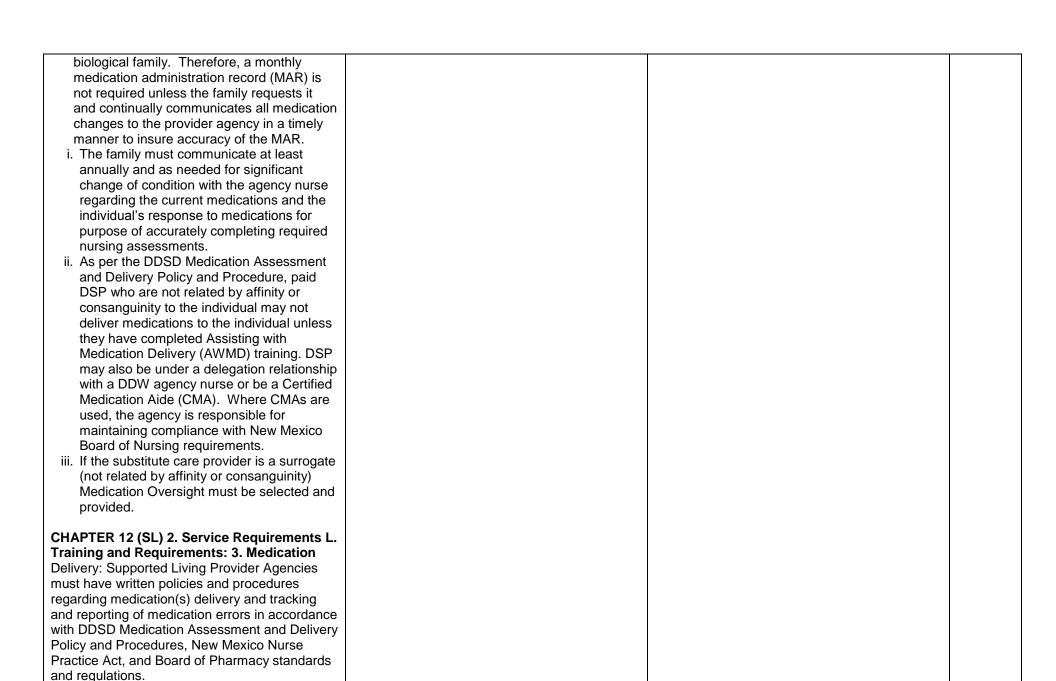
Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries:

 Synthroid 175mcg (1 time daily Monday through Saturday; 2 times daily on Sunday)
 Blank 3/8 (7:00 AM)

A. Living Supports- Family Living Services:			
The scope of Family Living Services includes,			
but is not limited to the following as identified by			
the Interdisciplinary Team (IDT):			
19. Assisting in medication delivery, and related			
monitoring, in accordance with the DDSD's			
Medication Assessment and Delivery Policy,			
New Mexico Nurse Practice Act, and Board of			
Pharmacy regulations including skill			
development activities leading to the ability for			
individuals to self-administer medication as			
appropriate; and			
I. Healthcare Requirements for Family Living.			
3. B. Adult Nursing Services for medication			
oversight are required for all surrogate Lining			
Supports- Family Living direct support personnel			
if the individual has regularly scheduled			
medication. Adult Nursing services for			
medication oversight are required for all			
surrogate Family Living Direct Support			
Personnel (including substitute care), if the			
individual has regularly scheduled medication.			
Support Living- Family Living Provider			
Agencies must have written policies and			
procedures regarding medication(s) delivery and			
tracking and reporting of medication errors in			
accordance with DDSD Medication Assessment			
and Delivery Policy and Procedures, the New			
Mexico Nurse Practice Act and Board of			
Pharmacy standards and regulations.			
a. All twenty-four (24) hour residential home			
sites serving two (2) or more unrelated			
individuals must be licensed by the Board of			
Pharmacy, per current regulations;			
b. When required by the DDSD Medication			
Assessment and Delivery Policy, Medication			
Administration Records (MAR) must be			
maintained and include:			
	1	1	

	i.The name of the individual, a transcription of		
	the physician's or licensed health care		
	provider's prescription including the brand		
	and generic name of the medication, and		
	diagnosis for which the medication is		
	prescribed;		
i	i.Prescribed dosage, frequency and		
	method/route of administration, times and		
	dates of administration;		
ii	i.Initials of the individual administering or		
	assisting with the medication delivery;		
į١	v.Explanation of any medication error;		
	v.Documentation of any allergic reaction or		
	adverse medication effect; and		
٧	i.For PRN medication, instructions for the use		
	of the PRN medication must include		
	observable signs/symptoms or		
	circumstances in which the medication is to		
	be used, and documentation of effectiveness		
	of PRN medication administered.		
C.	The Family Living Provider Agency must		
	also maintain a signature page that		
	designates the full name that corresponds to		
	each initial used to document administered		
	or assisted delivery of each dose; and		
d.	Information from the prescribing pharmacy		
	regarding medications must be kept in the		
	home and community inclusion service		
	locations and must include the expected		
	desired outcomes of administering the		
	medication, signs and symptoms of adverse		
	events and interactions with other		
	medications.		
e.	Medication Oversight is optional if the		
	individual resides with their biological family		
	(by affinity or consanguinity). If Medication		
	Oversight is not selected as an Ongoing		
	Nursing Service, all elements of medication		
	administration and oversight are the sole		

responsibility of the individual and their



a.	All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations;		
b.	When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:		
	 i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; 		
	ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;		
	iii. Initials of the individual administering or assisting with the medication delivery;		
i	iv. Explanation of any medication error;		
	v. Documentation of any allergic reaction or adverse medication effect; and		
,	vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.		
c.	The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to		

each initial used to document administered		
or assisted delivery of each dose; and		
d. Information from the prescribing pharmacy		
regarding medications must be kept in the		
home and community inclusion service		
locations and must include the expected		
desired outcomes of administrating the		
medication, signs, and symptoms of adverse events and interactions with other		
medications.		
modications.		
CHAPTER 13 (IMLS) 2. Service		
Requirements. B. There must be compliance		
with all policy requirements for Intensive Medical		
Living Service Providers, including written policy		
and procedures regarding medication delivery		
and tracking and reporting of medication errors		
consistent with the DDSD Medication Delivery		
Policy and Procedures, relevant Board of		
Nursing Rules, and Pharmacy Board standards and regulations.		
and regulations.		
Developmental Disabilities (DD) Waiver		
Service Standards effective 4/1/2007		
CHAPTER 1 II. PROVIDER AGENCY		
REQUIREMENTS:		
E. Medication Delivery: Provider		
Agencies that provide Community Living,		
Community Inclusion or Private Duty Nursing		
services shall have written policies and		
procedures regarding medication(s) delivery and tracking and reporting of medication errors		
in accordance with DDSD Medication		
Assessment and Delivery Policy and		
Procedures, the Board of Nursing Rules and		
Board of Pharmacy standards and regulations.		
(2) When required by the DDSD Medication		
Assessment and Delivery Policy, Medication		

Admir	nistration Records (MAR) shall be			
	ained and include:			
	The name of the individual, a			
()	transcription of the physician's written or			
	licensed health care provider's			
	prescription including the brand and			
	generic name of the medication,			
	diagnosis for which the medication is			
	prescribed;			
(b)	Prescribed dosage, frequency and			
` ,	method/route of administration, times			
	and dates of administration;			
(c)	Initials of the individual administering or			
, ,	assisting with the medication;			
(d)	Explanation of any medication			
	irregularity;			
(e)	Documentation of any allergic reaction			
	or adverse medication effect; and			
(f)	For PRN medication, an explanation for			
	the use of the PRN medication shall			
	include observable signs/symptoms or			
	circumstances in which the medication			
	is to be used, and documentation of			
	effectiveness of PRN medication			
	administered.			
	he Provider Agency shall also maintain a			
	ture page that designates the full name			
	orresponds to each initial used to			
	nent administered or assisted delivery of			
each	•			
	ARs are not required for individuals			
	pating in Independent Living who self-			
	nister their own medications;			
	formation from the prescribing pharmacy			
	ding medications shall be kept in the			
	and community inclusion service			
	ons and shall include the expected			
	ed outcomes of administrating the			
	ation, signs and symptoms of adverse			
avent	s and interactions with other medications:	I		1

Tag # 1A09.1	Standard Level Deficiency		
Medication Delivery			
PRN Medication Administration			
NMAC 16.19.11.8 MINIMUM STANDARDS:	Medication Administration Records (MAR) were	Provider:	
A. MINIMUM STANDARDS FOR THE	reviewed for the months of February and March	State your Plan of Correction for the	
DISTRIBUTION, STORAGE, HANDLING AND	2015.	deficiencies cited in this tag here: →	
RECORD KEEPING OF DRUGS:			
(d) The facility shall have a Medication	Based on record review, 1 of 16 individuals had		
Administration Record (MAR) documenting	PRN Medication Administration Records (MAR),		
medication administered to residents,	which contained missing elements as required		
including over-the-counter medications.	by standard:		
This documentation shall include:			
(i) Name of resident;	Individual #10		
(ii) Date given;	March 2015		
(iii) Drug product name;	No evidence of documented Signs/Symptoms		
(iv) Dosage and form;	were found for the following PRN medication:		
(v) Strength of drug;	• Ibuprofen 200mg – PRN – 3/6 (given 1 time)		
(vi) Route of administration;		Provider:	
(vii) How often medication is to be taken;		Enter your ongoing Quality Assurance/Quality	
(viii) Time taken and staff initials;		Improvement processes as it related to this tag	
(ix) Dates when the medication is		number here: →	
discontinued or changed;			
(x) The name and initials of all staff			
administering medications.			
Model Custodial Procedure Manual			
D. Administration of Drugs			
Unless otherwise stated by practitioner,			
patients will not be allowed to administer their			
own medications.			
Document the practitioner's order authorizing			
the self-administration of medications.			
All DDN (As possed of) medications at all to			
All PRN (As needed) medications shall have			
complete detail instructions regarding the			
administering of the medication. This shall include:			
symptoms that indicate the use of the			
medication,			
exact dosage to be used, and			
F Chact accage to be asea, and			1

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

medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications.

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

a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.). Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 1 SCOPE OF SERVICES** A. Living Supports- Family Living Services: The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): 19. Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy. New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate: and I. Healthcare Requirements for Family Living. **3. B.** Adult Nursing Services for medication oversight are required for all surrogate Lining Supports- Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication. 6. Support Living-Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and

tracking and reporting of medication errors in accordance with DDSD Medication Assessment

and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations.		
 f. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; g. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: 		
i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.		
h. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to		
each initial used to document administered or assisted delivery of each dose; and i. Information from the prescribing pharmacy regarding medications must be kept in the		

home and community inclusion service		
locations and must include the expected		
desired outcomes of administering the		
medication, signs and symptoms of adverse		
events and interactions with other		
medications.		
j. Medication Oversight is optional if the		
individual resides with their biological family		
(by affinity or consanguinity). If Medication		
Oversight is not selected as an Ongoing		
Nursing Service, all elements of medication		
administration and oversight are the sole		
responsibility of the individual and their		
biological family. Therefore, a monthly		
medication administration record (MAR) is		
not required unless the family requests it		
and continually communicates all medication		
changes to the provider agency in a timely		
manner to insure accuracy of the MAR.		
iv. The family must communicate at least		
annually and as needed for significant		
change of condition with the agency nurse		
regarding the current medications and the		
individual's response to medications for		
purpose of accurately completing required		
nursing assessments.		
v. As per the DDSD Medication Assessment		
and Delivery Policy and Procedure, paid		
DSP who are not related by affinity or		
consanguinity to the individual may not		
deliver medications to the individual unless		
they have completed Assisting with		
Medication Delivery (AWMD) training. DSP		
may also be under a delegation relationship		
with a DDW agency nurse or be a Certified		
Medication Aide (CMA). Where CMAs are		
used, the agency is responsible for		
maintaining compliance with New Mexico		
Board of Nursing requirements.		
vi. If the substitute care provider is a surrogate		
(not related by affinity or consanguinity)		

Medication Oversight must be selected and		
provided.		
CHAPTER 12 (SL) 2. Service Requirements L.		
Training and Requirements: 3. Medication		
Delivery: Supported Living Provider Agencies		
must have written policies and procedures		
regarding medication(s) delivery and tracking		
and reporting of medication errors in accordance		
with DDSD Medication Assessment and Delivery		
Policy and Procedures, New Mexico Nurse		
Practice Act, and Board of Pharmacy standards		
and regulations.		
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sites serving two (2) or more unrelated		
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Tharmady, por darronk regulations,		
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Assessment and Delivery Policy, Medication		
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provider's prescription including the brand		
and generic name of the medication, and		
diagnosis for which the medication is		
prescribed;		
ii. Prescribed dosage, frequency and		
method/route of administration, times and		
dates of administration;		
dates of darminoration,		
iii. Initials of the individual administering or		
assisting with the medication delivery;		
3		
iv. Explanation of any medication error;		
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	v. Documentation of any allergic reaction or adverse medication effect; and		
`	vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered.		
g.	The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and		
٦.	Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications.		
wi Mo wr of Mo re	HAPTER 13 (IMLS) 2. Service equirements. B. There must be compliance th all policy requirements for Intensive edical Living Service Providers, including itten policy and procedures regarding edication delivery and tracking and reporting medication errors consistent with the DDSD edication Delivery Policy and Procedures, levant Board of Nursing Rules, and narmacy Board standards and regulations.		
	evelopmental Disabilities (DD) Waiver		

CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: The objective of these

standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. E. Medication Delivery: Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medications) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; Prescribed dosage, frequency and method/route of administration; times and dates of administration; times and desteo of administration; (c) Initials of the individual administrating or assisting with the medication ir regularity; (e) Documentation of any allergic reaction or adverse medication of any of the process of the process of the process of the desteo of administration or any design or action or adverse medication of any of the process of the		
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(b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction		
method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction		
and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction		
(c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction	· ·	
assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction	· ·	
(d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction		
irregularity; (e) Documentation of any allergic reaction		
(e) Documentation of any allergic reaction		
	or adverse medication effect; and	

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

Tag # 1A15.2 and IS09 / 5l09 Healthcare Documentation	Standard Level Deficiency		
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy: All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.	Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 5 of 26 individual Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
Chapter 6 (CCS) 2. Service Requirements. E. The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the	Comprehensive Aspiration Risk Management Plan: Not Current (#15) Special Health Care Needs:		
individual's health status and medically related	Special Health Care Needs:	Provider:	
supports when receiving this service;	Nutritional Plan	Enter your ongoing Quality Assurance/Quality	
3. Agency Requirements: Consumer Records Policy: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.	 Individual #20 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. Daily Oral Care Supports Individual #23 - As indicated by the IST 	Improvement processes as it related to this tag number here: →	
Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy: All Provider Agencies must maintain at the administrative office	section of ISP the individual is required to have a plan. No evidence of a plan found.		
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.	Health Care Plans Aspiration Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No		
Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy: All Family Living	evidence of a plan found.		
Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. I. Health Care Requirements for Family Living:	 Falls Individual #4 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. 		
5. A nurse employed or contracted by the Family Living Supports provider must complete the e-	Status of Oral Hygiene		

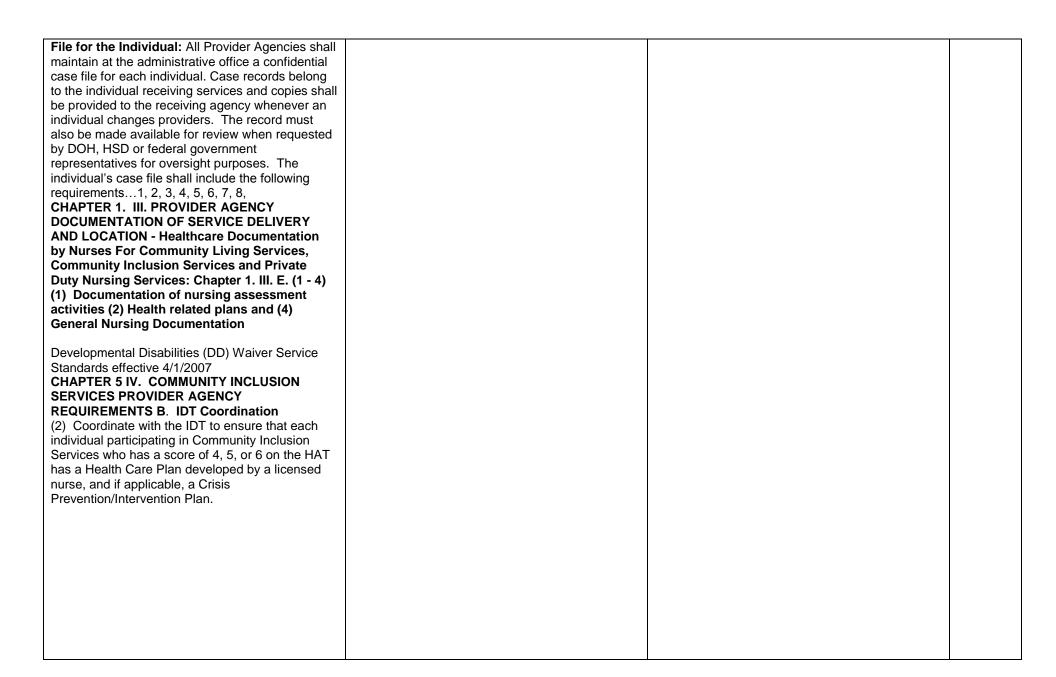
CHAT, the Aspiration Risk Screening Tool, (ARST), and the Medication Administration Assessment Tool (MAAT) and any other assessments deemed appropriate on at least an annual basis for each individual served, upon significant change of clinical condition and upon return from any hospitalizations. In addition, the MAAT must be updated for any significant change of medication regime, change of route that requires delivery by licensed or certified staff, or when an individual has completed training designed to improve their skills to support self-administration.	 Individual #5 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. 	
For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first.		
b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting.		
c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization.		
d. Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken);		

assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. e. Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.		
Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy: All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. 2. Service Requirements. L. Training and Requirements. 5. Health Related Documentation: For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following:		
a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home;		
b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated;		
c. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers		

	serving the individual. All interactions must be documented whether they occur by phone or in person; and
d.	Document for each individual that:
i	The individual has a Primary Care Provider (PCP);
ii	The individual receives an annual physical examination and other examinations as specified by a PCP;
iii	The individual receives annual dental check- ups and other check-ups as specified by a licensed dentist;
iv	The individual receives a hearing test as specified by a licensed audiologist;
V	The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and
vi	Agency activities occur as required for follow- up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine).
/ii	The agency nurse will provide the individual's team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually.
	The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards.
С	hapter 13 (IMLS) 2. Service Requirements:

C. Documents to be maintained in the agency administrative office, include: A. All assessments completed by the agency nurse, including the Intensive Medical Living Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall suffice;		
F. Annual physical exams and annual dental exams (not applicable for short term stays);		
G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for allowable exceptions for more frequent vision exam);		
H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements);		
I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange; J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay);		
L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay);		
O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays);		
P. Quarterly nursing summary reports (not applicable for short term stays);		
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible		

recipient who is currently receiving or who has received services in the past.		
B. Documentation of test results: Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.		
Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010		
F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.		
Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case		



T. #4407	0. 1 11 15 6		
Tag # 1A27	Standard Level Deficiency		
Incident Mgt. Late and Failure to Report			
NMAC 7.1.14 ABUSE, NEGLECT,	Based on the Incident Management Bureau's	Provider:	
EXPLOITATION, AND DEATH REPORTING,	Late and Failure Reports, the Agency did not	State your Plan of Correction for the	
TRAINING AND RELATED REQUIREMENTS	report suspected abuse, neglect, or exploitation,	deficiencies cited in this tag here: →	
FOR COMMUNITY PROVIDERS	unexpected and natural/expected deaths; or		
	other reportable incidents to the Division of		
NMAC 7.1.14.8 INCIDENT MANAGEMENT	Health Improvement, as required by regulations		
SYSTEM REPORTING REQUIREMENTS FOR	for 12 of 36 individuals.		
COMMUNITY-BASED SERVICE PROVIDERS:			
	Individual #3		
A. Duty to report:	 Incident date 11/19/2014. Allegation was 		
(1) All community-based providers shall	Neglect. Incident report was received on		
immediately report alleged crimes to law	11/23/2014. Late Reporting. IMB Late and		
enforcement or call for emergency medical	Failure Report indicated incident of Neglect		
services as appropriate to ensure the safety of	was "Open."		
consumers.	was open.	Provider:	
(2) All community-based service providers, their	Individual #23	Enter your ongoing Quality Assurance/Quality	
employees and volunteers shall immediately call	Incident date 9/3/2014. Allegation was	Improvement processes as it related to this tag	
the department of health improvement (DHI)	Neglect. Incident report was received on	number here: →	
hotline at 1-800-445-6242 to report abuse,	9/24/2014. Late Reporting. IMB Late and		
neglect, exploitation, suspicious injuries or any	Failure Report indicated incident of Neglect		
death and also to report an environmentally	was "Confirmed."		
hazardous condition which creates an immediate	was Committee.		
threat to health or safety.	Individual #27		
B. Reporter requirement. All community-based			
service providers shall ensure that the	Incident date 12/5/2013. Allegation was		
employee or volunteer with knowledge of the	Neglect. Incident report was received on		
alleged abuse, neglect, exploitation, suspicious	3/17/2014. Failure to Report. IMB Late and		
injury, or death calls the division's hotline to	Failure Report indicated incident of Neglect		
report the incident.	was "Unconfirmed."		
C. Initial reports, form of report, immediate	1. 1. 1. 1. 100		
action and safety planning, evidence	Individual #28		
preservation, required initial notifications:	 Incident date 3/26/2014. Allegation was 		
	Neglect. Incident report was received on		
(1) Abuse, neglect, and exploitation,	3/27/2014. Failure to Report. IMB Late and		
suspicious injury or death reporting: Any	Failure Report indicated incident of Neglect		
person may report an allegation of abuse,	was "Confirmed."		
neglect, or exploitation, suspicious injury or a			
death by calling the division's toll-free hotline	 Incident date 9/10/2014. Allegation was 		
number 1-800-445-6242. Any consumer,	Neglect. Incident report was received on		

- 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.
- (2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers: In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct

9/27/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect. was "Open."

Individual #29

- Incident date 5/17/2014. Allegation was Emergency Services. Incident report was received on 5/21/2014. IMB issued a Late Reporting for Emergency Services.
- Incident date 00/00/0000 [sic]. (Exact date of incident could not be determined.) Allegation was Abuse/Neglect. Incident report was received on 11/21/2014. Failure to Report. IMB Late and Failure Report indicated incident of Abuse/Neglect was "Unconfirmed."

Individual #30

 Incident date 9/6/2014. Allegation was Neglect. Incident report was received on 9/8/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Confirmed."

Individual #31

 Incident date 10/24/2014. Allegation was Neglect. Incident report was received on 10/27/2014. Late Reporting. IMB Late and Failure Report indicated incident of Neglect was "Open."

Individual #32

 Incident date 10/10/2014. Allegation was Neglect. Incident report was received on 11/5/2014. Failure to Report. IMB Late and Failure Report indicated incident of Neglect was "Open."

Individual #33

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

 Incident date 00/00/0000 [sic]. (Exact date of incident could not be determined.) Allegation was Abuse/Neglect. Incident report was received on 1/8/2015. Failure to Report. IMB Late and Failure Report indicated incident of Abuse/Neglect was "Open."

Individual #34

 Incident date 1/12/2015. Allegation was Unexpected Death. Incident report was received on 1/16/2015. IMB Late and Failure Report indicated incident was "Open."

Individual #35

 Incident date 00/00/0000 [sic]. (Exact date of incident could not be determined.) Allegation was Neglect/Exploitation. Incident report was received on 2/16/2015. Failure to Report. IMB Late and Failure Report indicated incident of Neglect/Exploitation was "Open."

Individual #36

Incident date 00/00/0000 [sic]. (Exact date of incident could not be determined.) Allegation was Abuse/Neglect. Incident report was received on 2/16/2015. Failure to Report. IMB Late and Failure Report indicated incident of Abuse/Neglect was "Open."

consumer's legal guardian or parent is notified		
of the alleged incident of abuse, neglect and		
exploitation within 24 hours of notice of the		
alleged incident unless the parent or legal		
guardian is suspected of committing the		
alleged abuse, neglect, or exploitation, in which		
case the community-based service provider		
shall leave notification to the division's		
investigative representative.		
(7) Case manager or consultant		
notification by community-based service		
providers: The responsible community-based		
service provider shall notify the consumer's		
case manager or consultant within 24 hours		
that an alleged incident involving abuse,		
neglect, or exploitation has been reported to		
the division. Names of other consumers and		
employees may be redacted before any		
documentation is forwarded to a case manager		
or consultant.		
(8) Non-responsible reporter: Providers		
who are reporting an incident in which they are		
not the responsible community-based service		
provider shall notify the responsible		
community-based service provider within 24		
hours of an incident or allegation of an incident		
of abuse, neglect, and exploitation		
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Tag # 1A27.2	Standard Level Deficiency		
Duty to Report IRs Filed During On-Site	Standard Level Denoising		
and/or IRs Not Reported by Provider			
•	Dood on record review the America did not	Provider:	
NMAC 7.1.14 ABUSE, NEGLECT,	Based on record review, the Agency did not		
EXPLOITATION, AND DEATH REPORTING,	report suspected abuse, neglect, or exploitation,	State your Plan of Correction for the	
TRAINING AND RELATED REQUIREMENTS	unexpected and natural/expected deaths; or	deficiencies cited in this tag here: →	
FOR COMMUNITY PROVIDERS	other reportable incidents to the Division of		
NIMAC 7 4 4 4 0 INCIDENT MANAGEMENT	Health Improvement for 1 of 26 Individuals.		
NMAC 7.1.14.8 INCIDENT MANAGEMENT	During the english common March O. 40, 0045		
SYSTEM REPORTING REQUIREMENTS FOR	During the on-site survey March 9 – 12, 2015,		
COMMUNITY-BASED SERVICE PROVIDERS:	surveyors found evidence 1 internal agency		
A Posterior manual	incident report, which had not been reported to		
A. Duty to report:	DHI, as required by regulation.		
(1) All community-based providers shall	The feller less lettered less less to the second of the second		
immediately report alleged crimes to law	The following internal incident was reported as a		
enforcement or call for emergency medical	result of the on-site survey:		
services as appropriate to ensure the safety of			
consumers.	Individual #25	Provider:	
(2) All community-based service providers, their	 Incident date 7/30/2014 (1:35 PM). Type of 	Enter your ongoing Quality Assurance/Quality	
employees and volunteers shall immediately call	incident identified was abuse. Incident was	Improvement processes as it related to this tag	
the department of health improvement (DHI)	brought to the attention of the Agency by	number here: →	
hotline at 1-800-445-6242 to report abuse,	Surveyors. Incident report was filed on		
neglect, exploitation, suspicious injuries or any	3/13/2015 by DHI/QMB.		
death and also to report an environmentally			
hazardous condition which creates an immediate			
threat to health or safety.			
B. Reporter requirement. All community-based			
service providers shall ensure that the			
employee or volunteer with knowledge of the			
alleged abuse, neglect, exploitation, suspicious			
injury, or death calls the division's hotline to			
report the incident.			
C. Initial reports, form of report, immediate			
action and safety planning, evidence			
preservation, required initial notifications:			
(1) Abuse, neglect, and exploitation,			
suspicious injury or death reporting: Any			
person may report an allegation of abuse,			
neglect, or exploitation, suspicious injury or a			
death by calling the division's toll-free hotline			

number 1-800-445-6242. Any consumer,	
family member, or legal guardian may call the	
division's hotline to report an allegation of	
abuse, neglect, or exploitation, suspicious	!
injury or death directly, or may report through	
the community-based service provider who, in	!
addition to calling the hotline, must also utilize	!
the division's abuse, neglect, and exploitation	!
or report of death form. The abuse, neglect,	!
and exploitation or report of death form and	!
instructions for its completion and filing are	!
available at the division's website,	!
http://dhi.health.state.nm.us, or may be	!
obtained from the department by calling the	
division's toll free hotline number, 1-800-445-	!
6242.	!
(2) Use of abuse, neglect, and exploitation	
or report of death form and notification by	!
community-based service providers: In	!
addition to calling the division's hotline as	!
required in Paragraph (2) of Subsection A of	!
7.1.14.8 NMAC, the community-based service	!
provider shall also report the incident of abuse,	
neglect, exploitation, suspicious injury, or death	!
utilizing the division's abuse, neglect, and	!
exploitation or report of death form consistent	
with the requirements of the division's abuse,	!
neglect, and exploitation reporting guide. The	
community-based service provider shall ensure	
all abuse, neglect, exploitation or death reports	
describing the alleged incident are completed	
on the division's abuse, neglect, and	
exploitation or report of death form and	
received by the division within 24 hours of the	
verbal report. If the provider has internet	
access, the report form shall be submitted via	
the division's website at	
http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The	
community-based service provider shall ensure that the reporter with the most direct	
mai me reporter with the most direct	

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

consumer's legal guardian or parent is notified		
of the alleged incident of abuse, neglect and		
exploitation within 24 hours of notice of the		
alleged incident unless the parent or legal		
guardian is suspected of committing the		
alleged abuse, neglect, or exploitation, in which		
case the community-based service provider		
shall leave notification to the division's		
investigative representative.		
(7) Case manager or consultant		
notification by community-based service		
providers: The responsible community-based		
service provider shall notify the consumer's		
case manager or consultant within 24 hours		
that an alleged incident involving abuse,		
neglect, or exploitation has been reported to		
the division. Names of other consumers and		
employees may be redacted before any		
documentation is forwarded to a case manager		
or consultant.		
(8) Non-responsible reporter: Providers		
who are reporting an incident in which they are		
not the responsible community-based service		
provider shall notify the responsible		
community-based service provider within 24		
hours of an incident or allegation of an incident		
of abuse, neglect, and exploitation		
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Tag # 1A28.2 Incident Mgt. System - Parent/Guardian	Standard Level Deficiency		
Training			
7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: A. General: All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. E. Consumer and guardian orientation packet: Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 16 of 26 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Parent/Guardian Incident Management Training on current reporting procedures. (Abuse, Neglect and Exploitation) (#1, 4, 5, 8, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 25, 26)	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →	

Tag # LS13 / 6L13	Standard Level Deficiency		
Community Living Healthcare Reqts.			
NMAC 8.302.1.17 RECORD KEEPING AND	Based on record review, the Agency did not	Provider:	
DOCUMENTATION REQUIREMENTS: A	provide documentation of annual physical	State your Plan of Correction for the	
provider must maintain all the records	examinations and/or other examinations as	deficiencies cited in this tag here: →	
necessary to fully disclose the nature, quality,	specified by a licensed physician for 5 of 16		
amount and medical necessity of services	individuals receiving Community Living Services.		
furnished to an eligible recipient who is			
currently receiving or who has received	Review of the administrative individual case files		
services in the past.	revealed the following items were not found,		
·	incomplete, and/or not current:		
B. Documentation of test results: Results of			
tests and services must be documented, which	Annual Physical (#16)		
includes results of laboratory and radiology	, ,		
procedures or progress following therapy or	Dental Exam		
treatment.	° Individual #19 - As indicated by the DDSD		
	file matrix Dental Exams are to be	Provider:	
Developmental Disabilities (DD) Waiver Service	conducted annually. No evidence of exam	Enter your ongoing Quality Assurance/Quality	
Standards effective 11/1/2012 revised 4/23/2013	was found.	Improvement processes as it related to this tag	
		number here: →	
Chapter 11 (FL) 3. Agency Requirements:	° Individual #23 - As indicated by the DDSD		
D. Consumer Records Policy: All Family	file matrix Dental Exams are to be		
Living Provider Agencies must maintain at the	conducted annually. No evidence of exam		
administrative office a confidential case file for	was found.		
each individual. Provider agency case files for			
individuals are required to comply with the	Vision Exam		
DDSD Individual Case File Matrix policy.	° Individual #21 - As indicated by the DDSD		
	file matrix, Vision Exams are to be		
Chapter 12 (SL) 3. Agency Requirements:	conducted every other year. No evidence of		
D. Consumer Records Policy: All Living	exam was found.		
Supports- Supported Living Provider Agencies	57.5.1.1 17.5.1.5.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1		
must maintain at the administrative office a	Auditory Exam		
confidential case file for each individual.	° Individual #12 - As indicated by collateral		
Provider agency case files for individuals are	documentation reviewed, exam was		
required to comply with the DDSD Individual	completed on 1/27/2014. Follow-up was to		
Case File Matrix policy.	be completed in 6 months. No evidence of		
	follow-up found.		
Developmental Disabilities (DD) Waiver	Tonon apround.		
Service Standards effective 4/1/2007	° Individual #23 - As indicated by collateral		
	documentation reviewed, exam was		

CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING

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

completed on 7/31/2012. Follow-up was to be completed in 1 year. No evidence of follow-up found.

• Mammogram Exam

o Individual #12 - As indicated by collateral documentation reviewed, exam was completed on 2/12/2014. Follow-up was to be completed in 12 months. No evidence of follow-up found.

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

Tag # LS25 / 6L25	Standard Level Deficiency		
Residential Health and Safety (SL/FL)			
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	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 10 of 11 Supported Living residences.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: →	
Living Services: 1. Family Living Services providers must assure that each individual's esidence is maintained to be clean, safe and comfortable and accommodates the individuals' laily living, social and leisure activities. In addition the residence must:	Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete:		
ne residence must.	Supported Living Requirements:		
 a. Maintain basic utilities, i.e., gas, power, water and telephone; 	Water temperature in home does not exceed safe temperature (110° F)		
b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e.,	 Water temperature in home measured 121°F (#7, 14, 16) 	Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag	
shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;	➤ Water temperature in home measured 115° F (#12, 22)	number here: →	
c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system;	➤ Water temperature in home measured 115.3° F (#10, 13)		
d. Have a general-purpose first aid kit;	 Water temperature in home measured 114.7° F (#15) 		
e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and	➤ Water temperature in home measured 139° F (#18)		
each individual has the right to have his or her own bed;	 Water temperature in home measured 128.5° F (#19) 		
 f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; 	 Water temperature in home measured 1205° F (#23) 		
g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are	 Water temperature in home measured 118° F (#26) 		

consistent with the Assisting with Medication Delivery training or each individual's ISP; and

h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding.

CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports-Supported Living Services: 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition the residence must:

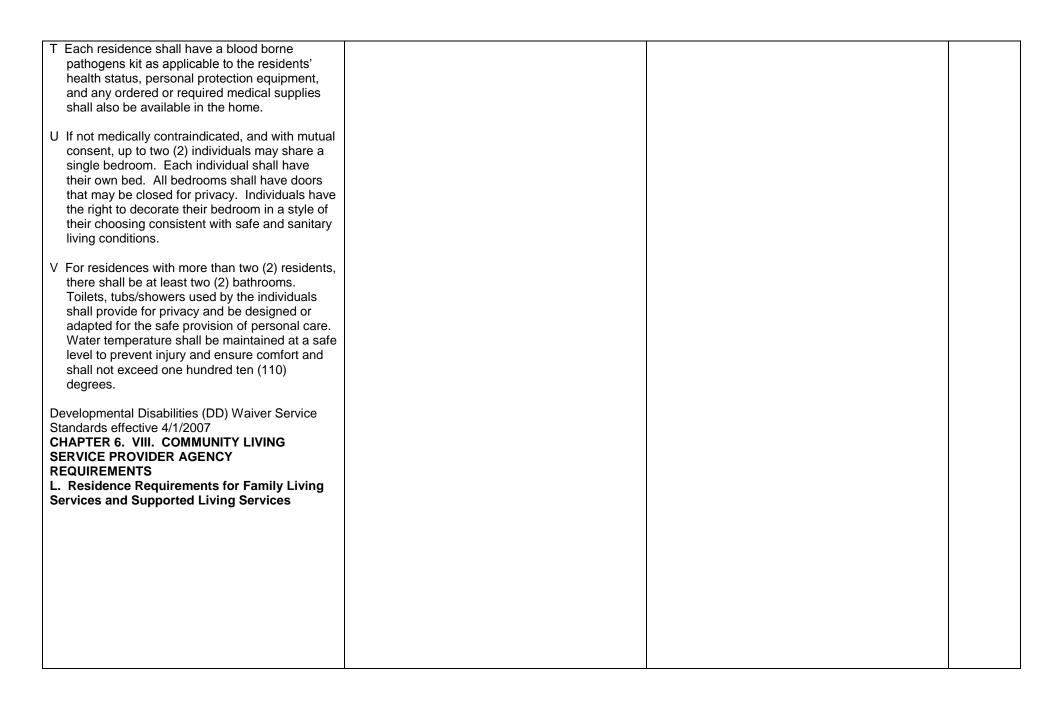
- a. Maintain basic utilities, i.e., gas, power, water, and telephone;
- b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT;
- c. Ensure water temperature in home does not exceed safe temperature (110°F);
- d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system;
- e. Have a general-purpose First Aid kit;
- f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and

- Water temperature in home measured 134.4° F (#6, 21)
- 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 (#12, 22)
- Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#20)

Note: The following Individuals share a residence:

- **>** #10, 13
- **7** #7, 14, 16
- **#12.22**
- **>** #6, 21

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



Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due		
		ists to assure that claims are coded and par	id for in		
	accordance with the reimbursement methodology specified in the approved waiver.				
Tag # IS25 / 5I25 Community Integrated	Standard Level Deficiency				
Employment Services /					
Supported Employment Reimbursement					
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 6. REIMBURSEMENT: A. 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. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007	Based on record review, the Agency did not provide written or electronic documentation as evidence for each unit billed for Supported Employment Services for 1 of 22 individuals Individual #5 December 2014 • The Agency billed 15 units of Community Integrated Employment Services (T2019 HB HQ) on 12/16/2014. Documentation received accounted for 14 units. • The Agency billed 23 units of Community Integrated Employment Services (T2019 HB HQ) on 12/19/2014. Documentation received accounted for 12 units.	Provider: State your Plan of Correction for the deficiencies cited in this tag here: → Provider: Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here: →			

CHAPTER 1 III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION

- A. General: All Provider Agencies shall maintain all records necessary to fully disclose the service, quality, quantity and clinical necessity furnished to individuals who are currently receiving services. The Provider Agency records shall be sufficiently detailed to substantiate the date, time, individual name, servicing Provider Agency, level of services, and length of a session of service billed.
- B. Billable Units: The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:
- Date, start and end time of each service encounter or other billable service interval;
- (2) A description of what occurred during the encounter or service interval; and
- (3) The signature or authenticated name of staff providing the service.

MAD-MR: 03-59 Eff 1/1/2004 8.314.1 BI RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:

Providers must maintain all records necessary to fully disclose the extent of the services provided to the Medicaid recipient. Services that have been billed to Medicaid, but are not substantiated in a treatment plan and/or patient records for the recipient are subject to recoupment.



Date: August 11, 2015

To: Deb Battista, Chief Executive Officer

Provider: Tresco, Inc.,

Address: 1700 Copper Loop

State/Zip: Las Cruces, New Mexico 88005

E-mail Address: <u>dbattista@trescoinc.org</u>

CC: Larry Dorbandt, Board Chair

Board Chair

E-Mail Address ldorbandt@zianet.com

Region: Southwest

Survey Date: March 9 – 12, 2014

Program Surveyed: Developmental Disabilities Waiver

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

Community Supports, Community Integrated Employment Services) and

Other (Customized In-Home Supports)

2007: Community Living (Supported Living) and Community Inclusion (Adult

Habilitation, Supported Employment)

Survey Type: Routine

Dear Ms. Battista:

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

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections.

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

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

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

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



Sincerely,

Amanda Castañeda

Amanda Castañeda Plan of Correction Coordinator Quality Management Bureau/DHI

Q.15.3.DDW.D1135.3.RTN.07.15.223