Date: August 19, 2016

To: Donna Hooten, Executive Director
Provider: Leaders Industries
Address: 115 West Dunnam
State/Zip: Hobbs, New Mexico 88240

E-mail Address: dhooten@leadersind.com

CC: Bill Morrill, Board Chair

E-mail Address: bmorrill1952@yahoo.com

Region: Southeast
Routine Survey: January 19 – 22, 2016
Verification Survey: August 2 – 3, 2016

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)

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

Survey Type: Verification

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

Dear Ms. Hooten;

The Division of Health Improvement/Quality Management Bureau has completed a Verification survey of the services identified above. The purpose of the survey was to determine compliance with your Plan of Correction submitted to DHI regarding the *Routine Survey on January 19 – 22, 2016*.

Determination of Compliance:

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

Compliance with Conditions of Participation.

However, due to the new/repeat standard level deficiencies your agency will be required to contact your DDSD Regional Office for technical assistance and follow up and complete the Plan of Correction document attached at the end of the this report. Please respond to the Plan of Correction Coordinator within 10 business days of receipt of this letter.

Plan of Correction:

The attached Report of Findings identifies the new/repeat Standard Level deficiencies found during your agency's verification compliance review. You are required to complete and implement a Plan of Correction. Your agency has a total of 10 business days from the receipt of this letter. The Plan of Correction must include the following:

1. Evidence your agency has contacted your DDSD Regional Office for technical assistance;
2. A Plan of Correction detailing Quality Assurance/Quality Improvement processes to prevent your agency from receiving deficiencies in the future. Please use the format provided at the end of this report;
3. Documentation verifying that newly cited deficiencies have been corrected.

Submission of your Plan of Correction:
Please submit your agency's Plan of Correction and documentation verifying correction of survey deficiencies within 10 business days of receipt of this letter to the parties below:

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

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

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

Please call the Plan of Correction Coordinator at 575-373-5716, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

Deb Russell

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

Survey Process Employed:

Entrance Conference Date:	August 2, 2016	
Present:	**Leaders Industries** Donna Hooten, Executive Director *(Provided information based on Administrative Needs List. Agency declined formal entrance meeting).*	
Exit Conference Date:	August 3, 2016	
Present:	**Leaders Industries** Paulie Gladden, Living Supports Administrator Norma Ornelas, Service Coordinator Tina Thompson, Customized Community Supports/Customized In-Home Supports Heather Pennell, Support Services **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor **DDSD - Southeast Regional Office** Michelle Lyon, Regional Program Manager, via telephone conference	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	13 3 - *Jackson* Class Members 10 - Non-*Jackson* Class Members 7 - Supported Living 1 - Independent Living 2 - Adult Habilitation 7 - Customized Community Supports 5 - Customized In-Home Supports
Persons Served Records Reviewed	Number:	13
Direct Support Personnel Records Reviewed	Number:	46
Service Coordinator Records Reviewed	Number:	1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Oversight of Individual Funds
- Individual Medical and Program Case Files, including, but not limited to:
    - Individual Service Plans
    - Progress on Identified Outcomes
    - Healthcare Plans
    - Medication Administration Records
    - Medical Emergency Response Plans
    - Therapy Evaluations and Plans
    - Healthcare Documentation Regarding Appointments and Required Follow-Up

- 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
MFEAD – NM Attorney General

Attachment B

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

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

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

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

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

Case Management Services:

- Level of Care
- Plan of Care
- Qualified Providers

Community Inclusion Supports/ Living Supports:

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

Conditions of Participation (CoPs)

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

QMB surveyors use professional judgment when reviewing the critical elements of each standard and regulation to determine when non-compliance with a standard level deficiency rises to the level of a CoP out of compliance. Only some deficiencies can rise to the level of a CoP (See the next section for a list of CoPs). The QMB survey team analyzes the relevant finding in terms of scope, actual harm or potential for harm, unique situations, patterns of performance, and other factors to determine if there is the potential for a negative outcome which would rise to the level of a CoP. A Standard level deficiency becomes a CoP out of compliance when the team's analysis establishes that there is an identified potential for

significant harm or actual harm. It is then cited as a CoP out of compliance. If the deficiency does not rise to the level of a CoP out of compliance, it is cited as a Standard Level Deficiency.

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

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

Service Domain: Level of Care

Condition of Participation:

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

Service Domain: Plan of Care

Condition of Participation:

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

Condition of Participation:

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

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

Service Domain: Qualified Providers

Condition of Participation:

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

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

Service Domain: Plan of Care

Condition of Participation:

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

Service Domain: Health, Welfare and Safety

Condition of Participation:

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

Condition of Participation:

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

QMB Determinations of Compliance

Compliance with Conditions of Participation

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

Partial-Compliance with Conditions of Participation

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

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

Non-Compliance with Conditions of Participation

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

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **Leaders Industries - Southeast Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living, Independent Living) and *Community Inclusion* (Adult Habilitation)
Monitoring Type: Verification Survey
Routine Survey: **January 19 – 22, 2016**
Verification Survey: **August 2 – 3, 2016**

Standard of Care	**Routine Survey Deficiencies January 19 – 22, 2016**	**Verification Survey New and Repeat Deficiencies August 2 – 3, 2016**
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # LS14 / 6L14 **Residential Case File**	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 7 of 7 Individuals receiving Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • Annual ISP (#3) • Individual Specific Training Section of ISP (formerly Addendum B) (#3) • Speech Therapy Plan (#4) • Healthcare Passport (#2, 3, 4, 5, 13, 14) • **Health Care Plans** ◦ Constipation (#4)	**New / Repeat Finding:** Based on record review, the Agency did not fully implement the Plan of Correction for Residential Case File. As stated in the Plan of Correction approved on 4/11/2016, "The Supported Living Administrator will develop a checklist of what documents are required to be kept in each client's residential file. Monthly checks will be done by program supervisors to insure the correct and current documents are in place within the files. Any documents not found during the file reviews will be noted and copies of those items will be requested from the Service Coordinator or Agency Nurse to be placed into the case files where needed." Residential file reviews were not completed at frequency described by the provider in the approved Plan of Correction.

(CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	◦ Falls (#4) ◦ Seizures (#4) • **Medical Emergency Response Plans** ◦ Cellulitis/Bursitis (#4) ◦ Constipation (#4) ◦ Falls (#4) ◦ Seizures (#4) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #2 - None found for 1/1 – 18, 2016. ◦ Individual #4 - None found for 1/1 – 18, 2016. ◦ Individual #6 - None found for 1/1 – 18, 2016. Individual #14 - None found for 1/1 – 18, 2016	Review of documentation indicated no monthly checks had been completed by program supervisors from 4/11/2016 through 8/3/2016.

Standard of Care	Routine Survey Deficiencies January 19 – 22, 2016	Verification Survey New and Repeat Deficiencies August 2 – 3, 2016
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A22 **Agency Personnel Competency**	**Condition of Participation Level Deficiency**	**Standard Level Deficiency**

Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS:
A. Individuals shall receive services from competent and qualified staff.
B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced.
 	
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1. All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment.
 	
CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1. All Customized Community Supports Providers
	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.
	
	Based on interview, the Agency did not ensure training competencies were met for 6 of 16 Direct Support Personnel.
	
	When DSP were asked what ISP Outcomes they are responsible for implementing, the following was reported:
	
	• DSP #212 stated, "That's something I don't do." (Individual #5)
	
	• DSP #227 asked, "What am I looking for in the ISP?" (Individual #6)
	
	• DSP #227 asked, "Like what do you mean? Coaching her to be more independent." (Individual #14)
	
	When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:
	
	• DSP #224 stated, "…does not have a BT. He moved away." According to the Individual Specific Training Section of the ISP, the Individual requires
		New / Repeat Finding:
		
		Based on record review, the Agency did not fully implement the Plan of Correction for Agency Personnel Competency.
		
		As stated in the Plan of Correction approved on 4/11/2016, "DS Staff will be re-trained on their job responsibilities by Program Administrators and/or Supervisors and will document the re-training."
		
		Based on record review, the Agency did not ensure training competencies were met for 2 of 16 Direct Support Personnel.
		
		Documentation of re-training was not found for the following:
		
		• DSP #212
		  ○ Health Care Plan – Bowel & Bladder (Individual #5)
		
		  ○ Medical Emergency Response Plan – High Risk Medications (Individual #5)
		
		  ○ Adverse Reaction to Food or Medication (Individual #5)
		
		• DSP #213

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	a Positive Behavioral Supports Plan. (Individual #3) • DSP #212 stated, "I don't know." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #13) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #224 stated, "I am not really sure off the top of my head." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #3) • DSP #212 stated, "Mmn hmn" and did not give a verbal response. According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #5) • DSP #227 stated, "No she doesn't." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #14) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #213 stated, "None." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Oral Care, Seizures, Falls and Spasticity. (Individual #2) • DSP #224 stated, "Like the Heimlich Maneuver." As indicated by the Electronic Comprehensive	○ Medical Emergency Response Plans – Seizures, Falls (Individual #2)

claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training: A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has	Health Assessment Tool, the Individual requires Health Care Plans for Body Mass Index, Oral Care, Respiratory and Constipation. Additionally, according to the Individual Specific Training Section of the ISP, the Individual requires Health Care Plans for Dental, Hypertension, PVD, High Body Mass Index and Hearing Deficit (Individual #3) • DSP #212 stated, "I don't remember any health care plans." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration and Bowel & Bladder. Additionally, according to the Individual Specific Training Section of the ISP, the Individual requires Health Care Plans for Skin Integrity and Diet Restrictions. (Individual #5) • DSP #212 stated, "Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plan for Constipation Management. Additionally, according to the Individual Specific Training Section of the ISP, the Individual requires Health Care Plans for Constipation, High Blood Pressure, Oral Hygiene and Self-Injurious Behavior. (Individual #13) **When DSP were asked if the Individual had any Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #213 stated, "No MERPs." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Seizures and Falls. (Individual #2)	

completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications. E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;	• DSP #224 stated, "The Medical Emergency Response Plans we would call the nurse, call 911 and it trickles down." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Respiratory. Additionally, according to the Individual Specific Training Section of the ISP, the Individual requires a Medical Emergency Response Plan for High Risk Medication. (Individual #3) • DSP #231 stated, "On seizures, just seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plan for Falls. Additionally, according to the Individual Specific Training Section of the ISP, the Individual requires Medical Emergency Response Plans for Falls and Constipation. (Individual #4) • DSP #212 stated, "Not that I know of, no." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Aspiration. Additionally, according to the Individual Specific Training Section of the ISP, the Individual requires Medical Emergency Response Plans for Aspiration and High Risk Medication. (Individual #5) **When DSP were asked if the Individual had any Bowel or Bladder issues, the following was reported:** • DSP #235 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Health Care Plan for Bowel Elimination R/T Irritable Bowel Syndrome Colitis (Individual #8)	

	When DSP were asked if the Individual had any requirements regarding food consistency and size, the following was reported: • DSP #245 stated, "Mechanical soft and small amounts of water." According to the Aspiration Risk Management Tool, the Individual requires "puree diet, thin liquids". (Individual #13) **When DSP were asked to describe the signs and symptoms of an Allergic Reaction to food and/or an Adverse Reaction to a medication, the following was reported:** • DSP #212 stated, "Tell you the truth. I don't know. Roll eyes. Go down to the floor. Couldn't speak." (Individual #5)	

Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Standard Level Deficiency
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:** **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **B. Training curriculum:** Prior to an employee or volunteer's initial work with the community-based service provider, all employees and volunteers shall be trained on an applicable written training curriculum including incident policies and procedures for identification, and timely reporting of abuse, neglect, exploitation, suspicious injury, and all deaths as required in Subsection A of 7.1.14.8 NMAC. The trainings shall be reviewed at annual, not to exceed 12-month intervals. The training curriculum as set forth in Subsection C of 7.1.14.9 NMAC may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the community-based service provider's facility. Training shall be conducted in a language that is understood by the employee or volunteer.	Based on record review and interview, the Agency did not ensure Incident Management Training for 8 of 48 Agency Personnel. **Direct Support Personnel (DSP):** • Incident Management Training (Abuse, Neglect and Exploitation) (DSP #229, 230, 243, 245) **When Direct Support Personnel were asked what State Agency must be contacted when there is suspected Abuse, Neglect and Exploitation, the following was reported:** • DSP #212 stated, "No not really. Done forgot." Staff was not able to identify the State Agency as Division of Health Improvement. • DSP #222 stated, "I would call her case manager, J & J, my supervisor and the Agency Executive Director. State IR." Staff was not able to identify the State Agency as Division of Health Improvement. **When DSP were asked to give examples Neglect, the following was reported:** • DSP #228 did not respond. **When DSP were asked to give examples Exploitation, the following was reported:** • DSP #212 stated, "Not off hand, no." • DSP #227 stated, "What do you mean? I'm not sure."	**New / Repeat Finding:** Based on record review, the Agency did not fully implement the Plan of Correction for Incident Management System – Personnel Training. As stated in the Plan of Correction approved on 4/11/2016, **"**Staff are trained upon hire and then annually on the Incident Management System Training and are walked through the process. As a support, there is a detailed procedure printed and placed in every residential home and program area that outlines exactly who needs to be contacted, when the reporting is required, etc. Supervisors have added this to their checklists that are done monthly to make sure DS Staff are familiar with the procedure and where it is located when they need to use it." Based on record review, the Agency did not ensure Incident Management Training for 1 of 47 Agency Personnel. **Documentation of monthly checklist was not found for the following:** • DSP #222 – Ability to identify the State Agency as Division of Health Improvement.

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 community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training	• DSP #229 stated, "I forgot."	

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

Standard of Care	Routine Survey Deficiencies January 19 – 22, 2016	Verification Survey New and Repeat Deficiencies August 2 – 3, 2016
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag #1A08.2 Healthcare Requirements	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release.	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 6 of 15 individuals receiving Community Inclusion, Living Services and Other Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Annual Physical** (#1) • **Dental Exam** ◦ Individual #1 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #1 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #11 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.	**Repeat Finding:** Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 13 individuals receiving Community Inclusion, Living Services and Other Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):*** • ***Vision Exam*** ◦ Individual #5 - As indicated by collateral documentation reviewed in the routine survey on Jan 19 – 22, 2016, the exam was completed on 7/14/2014. Follow-up was to be completed in 12 months. Documentation provided during the verification survey indicated insurance would not pay for an exam until 7/2017. The agency had no other documentation indicating how this was going to be addressed since exam indicated a follow-up to be completed.

H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements** **H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. **Chapter 6 (CCS) 3. Agency Requirements:** **G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 7 (CIHS) 3. Agency Requirements:** **E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements:**	***Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):*** • ***Annual Physical*** (#8) • ***Dental Exam*** ◦ Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 6/26/2015. Follow-up was to be completed in 6 months. No evidence of follow-up found. ◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #13 - 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 collateral documentation reviewed, exam was completed on 12/17/2014. Follow-up was to be completed in 12 months. No evidence of follow-up found. ◦ Individual #5 - As indicated by collateral documentation reviewed, exam was completed on 7/14/2014. Follow-up was to be completed in 12 months. No evidence of follow-up found. • ***Podiatry Exam*** ◦ Individual #8 - As indicated by collateral documentation reviewed, exam was completed on 10/2/2015. Follow-up was to be completed in 3 months. No evidence of follow-up found. • ***Primary Care Physician Appointment***	

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)… 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 provider. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements: (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING**	Individual #13 - As indicated by collateral documentation reviewed, exam was completed on 10/21/2015. Follow-up was to be completed in 1 month. No evidence of follow-up found.	

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

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

Standard of Care	Deficiencies	Agency Plan of Correction, On-going QA/QI and Responsible Party Date Due
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A08 Agency Case File	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # LS17 / 6L17 Reporting Requirements (Community Living Reports)	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A25 Criminal Caregiver History Screening	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 CQI System	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A07 Social Security Income (SSI) Payments	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09 Medication Delivery Routine Medication Administration	**Standard Level Deficiency**	**COMPLETE**

Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A27.2 Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A31 Client Rights/Human Rights	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A33 Board of Pharmacy – Med. Storage	**Standard Level Deficiency**	**COMPLETE**
Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # IH32 Customized In-Home Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag # LS14/6L14 **Residential Case File**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A22 **Agency Personnel Competency**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Tag # 1A28.1 **Incident Mgt. System - Personnel Training**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag #1A08.2 **Healthcare Requirements**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Date: September 21, 2016

To: Donna Hooten, Executive Director
Provider: Leaders Industries
Address: 115 West Dunnam
State/Zip: Hobbs, New Mexico 88240

E-mail Address: dhooten@leadersind.com

CC: Bill Morrill, Board Chair

E-mail Address: bmorrill1952@yahoo.com

Region: Southeast
Routine Survey: January 19 – 22, 2016
Verification Survey: August 2 – 3, 2016

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Living Supports* (Supported Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)

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

Survey Type: Verification

Dear Ms. Hooten;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.1.DDW.D0612.4.VER.09.16.265