

Date: March 23, 2016

To: Matthew Bardwell, Director
 Provider: Connections LLC
 Address: 217 San Pedro Drive NE
 State/Zip: Albuquerque, New Mexico 87108

E-mail Address: admin@connectionsnm.com

Region: Metro
 Routine Survey: March 23 - 26, 2015
 Verification Survey: February 23 – 24, 2016
 Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Inclusion Supports** (Customized Community Supports, Community Integrated Employment Services)
2007: Community Inclusion (Adult Habilitation, Community Access, Supported Employment)

Survey Type: Verification

Team Leader: Tony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality Management Bureau

Team Members: Kandis Gomez, AS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Mr. Bardwell;

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 March 23 – 26, 2015*.

Determination of Compliance:

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

Partial Compliance with Conditions of Participation

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

- Tag # 1A22 Agency Personnel Competency

Due to the new/repeat deficiencies your report of findings will be referred to the Internal Review Committee (IRC) for further action and potential sanctions. You will be contacted by the IRC for instructions on how to proceed. Please call the Plan of Correction Coordinator Amanda Castaneda at 575-373-5716 if you have questions about the Report of Findings. Thank you for your cooperation and for the work you perform.

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>



Sincerely,

Tony Fragua, BFA

Tony Fragua, BFA
Team Lead/DDW Program Manager
Division of Health Improvement / Quality Management Bureau

Survey Process Employed:

Entrance Conference Date: February 23, 2016

Present: **Connections, LLC**
Matthew Bardwell, Director of Operations
Debra Schaffer, Service Coordinator

DOH/DHI/QMB
Tony Fragua, BFA, Team Lead/DDW Program Manager
Kandis Gomez, AS, Healthcare Surveyor

Exit Conference Date: February 24, 2016

Present: **Connections, LLC**
Matthew Bardwell, Director
Debra Schaffer, Service Coordinator

DOH/DHI/QMB
Tony Fragua, BFA, Team Lead/DDW Program Manager
Kandis Gomez, AS, Healthcare Surveyor

Administrative Locations Visited Number: 1

Total Sample Size Number: 13

6 - Jackson Class Members
7 - Non-Jackson Class Members

6 - Adult Habilitation
1 - Community Access
2 - Supported Employment
6 - Customized Community Supports
5 - Community Integrated Employment Services

Persons Served Records Reviewed Number: 13

Direct Support Personnel Records Reviewed Number: 9 (Note: 2 DSP also perform a Service Coordinator and the other as the Director)

Service Coordinator Records Reviewed Number: 1

Administrative Processes and Records Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Individual Medical and Program Case Files, including, but not limited to:
 - Individual Service Plans
 - Progress on Identified Outcomes
 - Healthcare Plans
 - Medication Administration Records
 - Medical Emergency Response Plans
 - Therapy Evaluations and Plans
 - Healthcare Documentation Regarding Appointments and Required Follow-Up
 - Other Required Health Information
- Personnel Files, including nursing and subcontracted staff
- Staff Training Records, Including Competency Interviews with Staff
- Agency Policy and Procedure Manual

QMB Report of Findings – Connections, LLC – METRO Region – February 23 – 24, 2016

Survey Report #: Q.16.3.DDW.D0178.5.VER.01.16.083

- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- 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 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.

**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 IRC process, email the IRF Chairperson, Tony Fragua at Anthony.Fragua@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: Connections, LLC - Metro Region
Program: Developmental Disabilities Waiver
Service: 2012: Inclusion Supports (Customized Community Supports, Community Integrated Employment Services) & 2007: Community Inclusion (Adult Habilitation, Community Access, Supported Employment)
Monitoring Type: Verification Survey
Routine Survey: March 23 - 26, 2015
Verification Survey: February 23 – 24, 2016

Standard of Care	Routine Survey Deficiencies March 23 – 26, 2015	Verification Survey New and Repeat Deficiencies February 23 – 24, 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 # 1A08 Agency Case File	Standard Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p>Chapter 5 (CIES) 3. Agency Requirements</p> <p>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:</p> <ol style="list-style-type: none"> 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). <p>Chapter 6 (CCS) 3. Agency Requirements:</p> <p>G. Consumer Records Policy: All Provider Agencies shall maintain at the administrative</p>	<p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 14 of 16 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • MAD 046 (#7, 12, 14) • Current Emergency and Personal Identification Information <ul style="list-style-type: none"> ◦ Did not contain individuals current address (#5) ◦ Did not contain Pharmacy Information (#5, 12, 15) ◦ Did not contain Physician Information (#5) ◦ Did not contain Health Plan Information(#5, 12, 15, 16) • ISP Signature Page (#12) 	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 1 of 13 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Positive Behavioral Support Plan (#15) • Annual Physical (#15) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by collateral documentation reviewed, exam was completed on 11/20/2014. Follow-up was to be completed in 6 months. No evidence of follow-up found. • Vision Exam

<p>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. Additional documentation that is required to be maintained at the administrative office includes:</p> <ol style="list-style-type: none"> 1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD. <p>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.</p> <p>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.</p> <p>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.</p> <p>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)</p> <ul style="list-style-type: none"> • Emergency contact information; • Personal identification; 	<ul style="list-style-type: none"> • ISP Teaching and Support Strategies <ul style="list-style-type: none"> ◦ <i>Individual #5 - TSS not found for the following Action Steps:</i> <ul style="list-style-type: none"> ◦ (Work/Learn) Outcome Statement <ul style="list-style-type: none"> ➤ "...with assistance will work on job maintenance skills, that encompass safety, appearance and performance." ➤ "...with staff will review schedules, routes and cost of public transportation." ➤ "... with staff will use public transportation and discuss." ◦ <i>Individual #8 - TSS not found for the following Action Steps:</i> <ul style="list-style-type: none"> ◦ (Work/Learn)Outcome Statement <ul style="list-style-type: none"> ➤ "... will choose an activities/outings 2 times a week through the use of visual schedule/picture dictionary and verbalize his choice." ➤ "... will educate others on what items can be recycled." ➤ "...will make and post flyers stating that there will be a karaoke party and what date they will be." ◦ <i>Individual #10 - TSS not found for the following Action Steps:</i> <ul style="list-style-type: none"> ◦ (Relationships/Have Fun) Outcome Statement <ul style="list-style-type: none"> ➤ "Research recipes with instructions and needed supplies." ➤ "...and staff will create scented items." ◦ <i>Individual #12 - TSS not found for the following Action Steps:</i> 	<ul style="list-style-type: none"> ◦ <i>Individual #15 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.</i>
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<ul style="list-style-type: none"> • ISP budget forms and budget prior authorization; • ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI); • Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a short term stay; • Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; • Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable; • Progress notes written by DSP and nurses; • Signed secondary freedom of choice form; • Transition Plan as applicable for change of provider in past twelve (12) months. <p>DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director’s Release: Consumer Record Requirements eff. 11/1/2012</p> <p>III. Requirement Amendments(s) or Clarifications:</p> <p>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</p>	<ul style="list-style-type: none"> ◦ (Work/Education/Volunteer) Outcome Statement <ul style="list-style-type: none"> ➤ “... Will come prepared and focus on the school assignment and work on an outline, and review outline, and write/type her papers accordingly to complete the assignment toward her certificate.” ➤ “...will communicate with employer and job coach on work performance weekly to ensure problems are worked through and her standing at work is good.” ◦ Individual #16 - <i>TSS not found for the following Action Steps:</i> ◦ (Work/Education/Volunteer) Outcome Statement <ul style="list-style-type: none"> ➤ “...will discuss and practice paint schemes with automotive professionals in the community.” <ul style="list-style-type: none"> • Positive Behavioral Support Plan (#6, 7, 10, 15) • Behavior Crisis Intervention Plan (#6, 7, 8) • Speech Therapy Plan (#8, 11) • Occupational Therapy Plan (#14, 16) • Physical Therapy Plan (#10, 14) • Documentation of Guardianship/Power of Attorney (#8, 15) • Annual Physical (#5, 7, 10, 11, 12, 15) • Dental Exam <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. 	
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<p>accordance with the Individual Case File Matrix incorporated in this director's release.</p> <p>H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>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:</p> <ol style="list-style-type: none"> (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, 	<ul style="list-style-type: none"> ◦ Individual #7 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #10 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #11 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #12 - 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 collateral documentation reviewed, exam was completed on 2/5/2014. Follow-up was to be completed in 6 months. No evidence of follow-up found. ◦ Individual #15 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. <ul style="list-style-type: none"> • Vision Exam <ul style="list-style-type: none"> ◦ Individual #1 - As indicated by annual physical exam which was completed on 11/25/2014 a referral to for a vision exam was made. No evidence of vision exam being completed was found. ◦ 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 #3 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. 	
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<p>medications), immunizations, and most recent physical exam;</p> <p>(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</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #10 - 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. ◦ Individual #12 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #13 - As indicated by annual physical exam, which was completed on 9/4/2014, a referral to for a vision exam was made. No evidence of vision exam being completed was found. ◦ Individual #15 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. <ul style="list-style-type: none"> • Auditory Exam <ul style="list-style-type: none"> ◦ Individual #2 - As indicated by the DDSD file matrix Auditory Exams are to be conducted every 3 years. No evidence of exam was found. ◦ Individual #3 - As indicated by the DDSD file matrix Auditory Exams are to be conducted every 3 years. No evidence of exam was found. ◦ Individual #11 - As indicated by the DDSD file matrix Auditory Exams are to be conducted every 3 years. No evidence of exam was found. ◦ Individual #13 - As indicated by annual physical exam, which was completed on 9/4/2014, a 	
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referral to for an auditory was made. No evidence of auditory exam being completed was found.

- Individual #14 - As indicated by collateral documentation reviewed, exam was completed on 1/28/2014. Follow-up was to be completed in 12 months. No evidence of follow-up found.
- Individual #15 - As indicated by the DDSD file matrix Auditory Exams are to be conducted every 3 years. No evidence of exam was found.

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Standard Level Deficiency	Standard Level Deficiency
<p>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.</p> <p>C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP.</p> <p>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.</p>	<p>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 3 of 16 individuals.</p> <p>As indicated by Individuals' ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #5</p> <ul style="list-style-type: none"> • None found regarding: Work/Education/Volunteer Outcome Action Step: "... with staff will review schedules, routes and cost of public transportation" for 1/2015 - 2/2015. <p>Individual #11</p> <ul style="list-style-type: none"> • According to the Live, Work/Learn, Fun Outcome; Action Step for "... and his support staff will create a lesson plan for ASL classes" is to be completed 2 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2014 and 2/2015. • According to the Work/Education/Volunteer; Action Step for "... and his staff will create needed documents via the computer and print copies for class" is to be completed 2 times per month, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 12/2014 and 2/2015. 	<p>Repeat Finding:</p> <p>Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcome and action plan for 1 of 13 individuals.</p> <p>As indicated by Individuals' ISP the following was found with regards to the implementation of ISP Outcomes:</p> <p>Administrative Files Reviewed:</p> <p>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #5</p> <ul style="list-style-type: none"> • None found regarding: Work/Education/Volunteer Outcome Action Step: "...with assistance will work on job maintenance skills, that encompass safety skills, appearance and performance" for 2/1 – 19, 2016. Action step is to be completed 1 time weekly.

<p>[05/03/94; 01/15/97; Recompiled 10/31/01]</p>	<ul style="list-style-type: none"> • None found regarding: Work/Education/Volunteer; Action Step for "... and his staff will create needed documents via the computer and print copies for class" 2 times per month, for 1/2015. • According to the Relationships/Have Fun Outcome; Action Step for "...will attend and participate in class." is to be completed weekly, evidence found indicated it was not being completed at the required frequency for 1/2015 and 2/2015 <p>Individual #12</p> <ul style="list-style-type: none"> • None found regarding: Work/Education/Volunteer Outcome Action Step: "... will come prepared and focus on the school assignment and work on an outline, and review outline, and write/type her papers accordingly to complete the assignment toward her certificate" for 12/2014 - 2/2015. <p>Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:</p> <p>Individual #5</p> <ul style="list-style-type: none"> • None found regarding: Work/Education/Volunteer Outcome Action Step: "...with assistance will work on job maintenance skills, that encompass safety skills, appearance and performance" for 12/2014 - 2/2015. <p>Individual #11</p> <ul style="list-style-type: none"> • None found regarding: Work/Education/Volunteer; Action Step for "... and his staff will create needed documents via the computer and print copies for class" for 1/2015. • None found regarding: 	
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Action Step for Work/Education/Volunteer outcome: "... will attend and participate in class." For 1/2015 - 2/2015

Individual #12

- None found regarding:
Work/Education/Volunteer Outcome Action Step: "...will communicate with employer and job coach on work performance weekly to ensure problems are worked through and her standing at work if good" for 12/2014 - 2/2015.

Tag # IS22 / 5I22 SE Agency Case File	Standard Level Deficiency	Standard Level Deficiency
<p>New Mexico Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy Policy Title: Vocational Assessment Profile Policy Off July 16, 2008</p> <p>I. PURPOSE: The intent of the policy is to ensure that individuals are identified who could benefit from Vocational Assessment Profiles (VAPs) and are supported to access this support.</p> <p>II. POLICY STATEMENT: Individuals served under the Developmental Disabilities Medicaid Waiver (DDW) who express an interest in obtaining employment or exploring employment opportunities, or individuals who desire a VAP and those whose teams identify that they could benefit from a VAP, will have access to a VAP in accordance to the DDW Service Standards and related procedures.</p> <p>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:</p> <ol style="list-style-type: none"> 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 	<p>Based on record review, the Agency did not maintain a confidential case file for each individual receiving Community Integrated Employment Services / Supported Employment Services for 3 of 16 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Required Certificates and Documentation <ul style="list-style-type: none"> ◦ Current pay stubs. (#12, 13, 15) 	<p>Repeat Finding:</p> <p>Based on record review, the Agency did not maintain a confidential case file for each individual receiving Community Integrated Employment Services / Supported Employment Services for 1 of 7 individuals.</p> <p>Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Required Certificates and Documentation <ul style="list-style-type: none"> ◦ Current pay stubs. (#13)

available under the Rehabilitation Act of 1973 (DVR).

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

CHAPTER 5 VII. SUPPORTED EMPLOYMENT SERVICES REQUIREMENTS

D. Provider Agency Requirements

(1) Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the DDS. Each individual's earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual's earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.

(2) The Provider Agency shall maintain a confidential case file for each individual that includes all items listed in section IV.D. above and the following additional items:

(a) Quarterly progress reports;

(b) Vocational assessments (A vocational assessment or profile is an objective analysis of a person's interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or DDS;

(c) Career development plan as incorporated in the ISP; a career development plan consists of the vocational assessment and the ISP Work/Learn Action Plan that specifies steps

<p>necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability; and</p> <p>(d) Documentation of decisions concerning the Division of Vocational Rehabilitation that services provided under the Waiver are not otherwise available under the Rehabilitation Act of 1973.</p>		
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Standard of Care	Routine Survey Deficiencies March 23 – 26, 2015	Verification Survey New and Repeat Deficiencies February 23 – 24, 2016
<p>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.</p>		
<p>Tag # 1A22 Agency Personnel Competency</p>	<p>Condition of Participation Level Deficiency</p>	<p>Condition of Participation Level Deficiency</p>
<p>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.</p> <p>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.</p> <p>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;</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on interview, the Agency did not ensure training competencies were met for 6 of 10 Direct Support Personnel.</p> <p>When DSP were asked if they received training on the Individual’s Individual Service Plan and what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #201 stated, “No.” (Individual #15) <p>When DSP were asked if the individual require a physical restraint, the following was reported:</p> <ul style="list-style-type: none"> • DSP #209 stated, “If he becomes physical we can MANDT him.” According to the individuals Positive Behavior Support Crisis Plan, the Individual does not require any physical restraints. (Individual #1) <p>When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #209 stated, “When he is upset take him out and somewhere quiet. Also when he’s physically aggressive we can use restraints.” According to the Individual Specific Training Section of the 	<p>Repeat Finding:</p> <p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review the Agency did not ensure training competencies were met for 2 of 9 Direct Support Personnel.</p> <p>During on site Verification Survey on February 23 – 24, 2016, surveyors asked for evidence that DSP’s cited in the March 2016 routine survey received training regarding Agency Personnel Competency. The following was found:</p> <p>Individual’s Individual Service Plan</p> <ul style="list-style-type: none"> • DSP #201 - Agency could not provide documentation indicating DSP #201 had received training on the Individual’s Service Plan. (Individual #15) <p>Occupational Therapy Plan</p> <ul style="list-style-type: none"> • DSP #202 - Agency could not provide documentation indicating DSP #202 had received training on the Individual’s Occupational Therapy Plan. (Individual #10) <p>Health Care Plans:</p> <ul style="list-style-type: none"> • DSP #201 - Agency could not provide documentation indicating DSP #201 had received

<p>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.</p> <p>CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:</p> <p>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</p>	<p>ISP, the individual has Positive Behavioral Crisis Plan. The plan does not state any use of restraints other than Line of Sight. (Individual #1)</p> <p>When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #202 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #10) <p>When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #202 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Physical Therapy Plan. (Individual #10) <p>When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:</p> <ul style="list-style-type: none"> • DSP #209 stated, "He has no healthcare plans." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Aspiration. (Individual #1) • DSP #203 stated, "He has one for aspiration, skin/wound, constipation, seizures, and bowel/bladder." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for Falls. (Individual #3) • DSP #207 stated, "He has one for falls. " As indicated by the Individual Specific Training section of the ISP the Individual requires Health 	<p>training on the Individual's Health Care Plan for falls. (Individual #6)</p> <ul style="list-style-type: none"> • DSP #201 - Agency could not provide documentation indicating DSP #201 had received training on the Individual's Health Care Plans for Elevated Cholesterol, Body Mass Index, Hypertension, and Falls. (Individual #15) <p>Medical Emergency Response Plans:</p> <ul style="list-style-type: none"> • DSP #201 - Agency could not provide documentation indicating DSP #201 had received training on the Individual's Medical Emergency Response Plans for Falls. (Individual #6) • DSP #201 - Agency could not provide documentation indicating DSP #201 had received training on the Individual's Medical Emergency Response Plan for Falls and Hypertension. (Individual #15) <p>Food and/or medication allergies that could be potentially life threatening:</p> <ul style="list-style-type: none"> • DSP #201 - Agency could not provide documentation indicating DSP #201 had received training on the Individual's medication allergy to Penicillin. (Individual #6)
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<p>and Documentation for DDSD Training Requirements.</p> <p>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.</p> <p>CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:</p> <p>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.</p> <p>B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies,</p>	<p>Care Plans for Alteration in blood pressure and Seizures. (Individual #4)</p> <ul style="list-style-type: none"> • DSP #201 stated, "He has SLP and BSC." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for falls. (Individual #6) • DSP #201 stated, "He has one for BSC and seizures." As indicated by the Individual Specific Training section of the ISP the Individual requires Health Care Plans for Elevated Cholesterol, Body Mass Index, Hypertension, and Falls.(Individual #15) <p>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:</p> <ul style="list-style-type: none"> • DSP #203 stated, "He has one for constipation, seizure, and aspiration." According to the Individual Specific Training section of the ISP the Individual also requires a Medical Emergency Response Plan for: Falls (Individual #3) • DSP #201 stated, "None." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plans for Falls. (Individual #6) • DSP #209 stated, "He has seizure, aspiration, falls and low sodium." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Respiratory .(Individual #8) • DSP #201 stated, "He has a MERP for seizures." As indicated by the Individual Specific Training section of the ISP the Individual requires Medical 	
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<p>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.</p> <p>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;</p>	<p>Emergency Response Plan for Falls and Hypertension.(Individual #15)</p> <p>When DSP were asked if they received training specific to the Individuals Seizure Disorder, the following was reported:</p> <ul style="list-style-type: none"> • DSP #207 stated, "No specific training...just what I learned in CPR/First Aid." As indicated by the Individual Specific Training section of the ISP DSP are required to receive training specific to seizures. (Individual #4) <p>When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:</p> <ul style="list-style-type: none"> • DSP #209 stated, "No." As indicated by Electronic Comprehensive Health Assessment Tool the individual is allergic to valium. (Individual #1) • DSP #204 stated, "No just seasonal." As indicated by Electronic Comprehensive Health Assessment Tool the individual is allergic to Zoloft. (Individual #2) • DSP #201 stated, "No." As indicated by Electronic Comprehensive Health Assessment Tool the individual is allergic to Penicillin. (Individual #6) 	
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Tag # 1A28.1 Incident Mgt. System - Personnel Training	Standard Level Deficiency	Standard Level Deficiency
<p>NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS</p> <p>NMAC 7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS:</p> <p>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.</p> <p>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.</p> <p>C. Incident management system training curriculum requirements:</p> <p>(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:</p> <p>(a) an overview of the potential risk of abuse, neglect, or exploitation;</p> <p>(b) informational procedures for properly filing the division's abuse, neglect, and exploitation or report of death form;</p>	<p>Based on record review and interview, the Agency did not ensure Incident Management Training for 6 of 14 Agency Personnel.</p> <p>Direct Support Personnel (DSP):</p> <ul style="list-style-type: none"> Incident Management Training (Abuse, Neglect and Exploitation) (DSP# 200, 204, 213) <p>When Direct Support Personnel were asked what two State Agencies must be contacted when there is suspected Abuse, Neglect and Exploitation, the following was reported:</p> <ul style="list-style-type: none"> DSP #207 stated, "APS." When DSP was asked if there was another State agency it would be reported to DSP #207 stated, "I would report to APS." Staff was not able to identify DHI/IMB. DSP #201 stated, "Report immediately to the state." Staff was not able to identify the State Agency as DHI/IMB. DSP #202 stated, "Adult Protective Services. Poster is in staff office." Staff was not able to identify the State Agency as DHI/IMB. 	<p>Repeat Finding:</p> <p>Based on record review and interview, the Agency did not ensure Incident Management Training for 1 of 9 Agency Personnel.</p> <p>During on site Verification Survey on February 23 – 24, 2016, surveyors asked for evidence that DSP's cited in the March 2016 routine survey received training regarding the Incident Management System. The following was found:</p> <ul style="list-style-type: none"> DSP #202 - Agency could not provide documentation indicating DSP #202 had received trained on Incident Management (Abuse, Neglect and Exploitation).

<p>(c) specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and exploitation, suspicious injury, and all deaths;</p> <p>(d) specific instructions on how to respond to abuse, neglect, or exploitation;</p> <p>(e) emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, exploitation, or suspicious injury.</p> <p>(2) All current employees and volunteers shall receive training within 90 days of the effective date of this rule.</p> <p>(3) All new employees and volunteers shall receive training prior to providing services to consumers.</p> <p>D. Training documentation: All community-based service providers shall prepare training documentation for each employee and volunteer to include a signed statement indicating the date, time, and place they received their incident management reporting instruction. The community-based service provider shall maintain documentation of an employee or volunteer's training for a period of at least three years, or six months after termination of an employee's employment or the volunteer's work. Training curricula shall be kept on the provider premises and made available upon request by the department. Training documentation shall be made available immediately upon a division representative's request. Failure to provide employee and volunteer training documentation shall subject the community-based service provider to the penalties provided for in this rule.</p> <p>Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 II.</p> <p>POLICY STATEMENTS:</p> <p>A. Individuals shall receive services from competent and qualified staff.</p> <p>C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13.</p>		
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Standard of Care	Routine Survey Deficiencies March 23 – 26, 2015	Verification Survey New and Repeat Deficiencies February 23 – 24, 2016
<p>Service Domain: Health and Welfare – <i>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.</i></p>		
Tag # 1A03 CQI System	Standard Level Deficiency	Standard Level Deficiency
<p>STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS</p> <p>d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met. The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include:</p> <ol style="list-style-type: none"> i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes; iii. The types of information used to measure performance; and, iv. The frequency with which performance is measured. 	<p>Based on record review, the Agency did not implement their Continuous Quality Management System as required by standard.</p> <p>Review of the Agency's CQI Plan revealed the following:</p> <ul style="list-style-type: none"> • The Agency's CQI Plan did not contain the following components: <ol style="list-style-type: none"> a. Compliance with Caregivers Criminal History Screening requirements; b. Compliance with Employee Abuse Registry requirements; c. Sufficiency of staff coverage; <p>In addition, review of the findings identified during the on-site survey (March 23-26, 2015) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency.</p>	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not develop and implement a Continuous Quality Management System.</p> <p>Review of the findings from the February 23 – 24, 2016 survey indicated the Agency had multiple deficiencies noted, including a Condition of Participation. Nevertheless, during the verification survey the agency continues to have substantial deficiencies, which either were not corrected nor addressed since the last survey.</p>

<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p>CHAPTER 5 (CIES) 3. Agency Requirements: J. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.</p> <p>1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:</p> <p>a. Implementation of ISPs: extent to which services are delivered in accordance with ISPs and associated support plans with WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;</p>		
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<p>3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDS; the report must be submitted to the relevant DDS Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> a. Analysis of General Events Reports data in Therap; b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDS training requirements; e. Patterns of reportable incidents; f. Results of improvement actions taken in previous quarters; g. Sufficiency of staff coverage; h. Effectiveness and timeliness of implementation of ISPs, and associated support including trends in achievement of individual desired outcomes; i. Results of General Events Reporting data analysis; j. Action taken regarding individual grievances; k. Presence and completeness of required documentation; l. A description of how data collected as part of the agency's QA/QI Plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QA/QI process; and m. Significant program changes. <p>CHAPTER 6 (CCS) 3. Agency Requirements: I. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.</p>		
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<p>1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QI Committee: The QA/QI committee shall convene at least quarterly and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting shall be documented. The QA/QI review should address at least the following:</p> <ul style="list-style-type: none"> a. The extent to which services are delivered in accordance with ISPs, associated support plans and WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns of reportable incidents; and g. Results of improvement actions taken in previous quarters. <p>3. The Provider Agencies must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review</p>		
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- by DOH and upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:
- a. Sufficiency of staff coverage;
 - b. Effectiveness and timeliness of implementation of ISPs, associated support plans, and WDSI, including trends in achievement of individual desired outcomes;
 - c. Results of General Events Reporting data analysis;
 - d. Action taken regarding individual grievances;
 - e. Presence and completeness of required documentation;
 - f. A description of how data collected as part of the agency's QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
 - g. Significant program changes.

CHAPTER 7 (CIHS) 3. Agency Requirements: G. Quality Assurance/Quality Improvement (QA/QI) Program:

Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to

<p>evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:</p> <p>a. Implementation of ISPs: The extent to which services are delivered in accordance with ISPs and associated support plans and/or WDSI including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;</p> <p>b. Analysis of General Events Reports data;</p> <p>c. Compliance with Caregivers Criminal History Screening requirements;</p> <p>d. Compliance with Employee Abuse Registry requirements;</p> <p>e. Compliance with DDSD training requirements;</p> <p>f. Patterns of reportable incidents; and</p> <p>g. Results of improvement actions taken in previous quarters.</p> <p>3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise request by DOH. The report must be kept on file at the agency, made available for review by DOH and, upon request from DDSD the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:</p> <p>a. Sufficiency of staff coverage;</p>		
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<p>b. Effectiveness and timeliness of implementation of ISPs and associated support plans and/or WDSI, including trends in achievement of individual desired outcomes;</p> <p>c. Results of General Events Reporting data analysis;</p> <p>d. Action taken regarding individual grievances;</p> <p>e. Presence and completeness of required documentation;</p> <p>f. A description of how data collected as part of the agency's QA/QI plan was used; what quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and</p> <p>g. Significant program changes.</p> <p>CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program: Family Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.</p> <p>1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to</p>		
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<p>evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:</p> <ul style="list-style-type: none"> a. The extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Analysis of General Events Reports data; c. Compliance with Caregivers Criminal History Screening requirements; d. Compliance with Employee Abuse Registry requirements; e. Compliance with DDSD training requirements; f. Patterns in reportable incidents; and g. Results of improvement actions taken in previous quarters. <p>3. The Provider Agency must complete a QA/QI report annually by February 15th of each year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes; c. Results of General Events Reporting data analysis, Trends in category II significant events; d. Patterns in medication errors; e. Action taken regarding individual grievances; 		
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- f. Presence and completeness of required documentation;
- g. A description of how data collected as part of the agency's QI plan was used;
- h. What quality improvement initiatives were undertaken and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
- i. Significant program changes.

CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program:

Supported Living Provider Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QA/QI activities.

1. Development of a QA/QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.

2. Implementing a QA/QI Committee: The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:

<p>a. Implementation of the ISP and the extent to which services are delivered in accordance with the ISP including the type, scope, amount, duration, and frequency specified in the ISP as well as effectiveness of such implementation as indicated by achievement of outcomes;</p> <p>b. Analysis of General Events Reports data;</p> <p>c. Compliance with Caregivers Criminal History Screening requirements;</p> <p>d. Compliance with Employee Abuse Registry requirements;</p> <p>e. Compliance with DDS training requirements;</p> <p>f. Patterns in reportable incidents; and</p> <p>g. Results of improvement actions taken in previous quarters.</p> <p>2.The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH, and upon request from DDS the report must be submitted to the relevant DDS Regional Offices. The report will summarize:</p> <p>a. Sufficiency of staff coverage;</p> <p>b. Effectiveness and timeliness of implementation of ISPs, including trends in achievement of individual desired outcomes;</p> <p>c. Results of General Events Reporting data analysis, Trends in Category II significant events;</p> <p>d. Patterns in medication errors;</p> <p>e. Action taken regarding individual grievances;</p> <p>f. Presence and completeness of required documentation;</p> <p>g. A description of how data collected as part of the agency's QA/QI plan was used, what quality improvement initiatives were undertaken, and the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and</p> <p>h. Significant program changes.</p> <p>CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI)</p>		
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<p>Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.</p> <p>1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:</p> <ul style="list-style-type: none"> a. Implementation of the ISPs, including the extent to which services are delivered in accordance with the ISPs and associated support plans and /or WDSI including the type, scope, amount, duration, and frequency specified in the ISPs as well as effectiveness of such implementation as indicated by achievement of outcomes; b. Trends in General Events as defined by DDS; c. Compliance with Caregivers Criminal History Screening Requirements; d. Compliance with DDS training requirements; 		
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<p>e. Trends in reportable incidents; and f. Results of improvement actions taken in previous quarters.</p> <p>3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> a. Sufficiency of staff coverage; b. Effectiveness and timeliness of implementation of ISPs and associated Support plans and/or WDSI including trends in achievement of individual desired outcomes; c. Trends in reportable incidents; d. Trends in medication errors; e. Action taken regarding individual grievances; f. Presence and completeness of required documentation; g. How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and h. Significant program changes. <p>CHAPTER 14 (ANS) 3. Service Requirements: N. Quality Assurance/Quality Improvement (QA/QI) Program: Agencies must develop and maintain an active QA/QI program in order to assure the provision of quality services. This includes the development of a QA/QI plan, data gathering and analysis, and routine meetings to analyze the results of QI activities.</p> <p>1. Development of a QI plan: The quality management plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The quality management plan describes the process the Provider Agency uses in</p>		
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<p>each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The quality management plan should describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working.</p> <p>2. Implementing a QA/QI Committee: The QA/QI committee shall convene on at least on a quarterly basis and as needed to review service reports, to identify any deficiencies, trends, patterns or concerns, as well as opportunities for quality improvement. For Intensive Medical Living providers, at least one nurse shall be a member of this committee. The QA meeting shall be documented. The QA review should address at least the following:</p> <ul style="list-style-type: none"> a. Trends in General Events as defined by DDSD; b. Compliance with Caregivers Criminal History Screening Requirements; c. Compliance with DDSD training requirements; d. Trends in reportable incidents; and e. Results of improvement actions taken in previous quarters. <p>3. The Provider Agency must complete a QA/QI report annually by February 15th of each calendar year, or as otherwise requested by DOH. The report must be kept on file at the agency, made available for review by DOH and upon request from DDSD; the report must be submitted to the relevant DDSD Regional Offices. The report will summarize:</p> <ul style="list-style-type: none"> a. Sufficiency of staff coverage; b. Trends in reportable incidents; c. Trends in medication errors; d. Action taken regarding individual grievances; e. Presence and completeness of required documentation; f. How data collected as part of the agency's QA/QI was used, what quality improvement initiatives were undertaken, and what were the 		
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results of those efforts, including discovery and remediation of any service delivery deficiencies discovered through the QI process; and
g. Significant program changes

NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:

F. Quality assurance/quality improvement program for community-based service providers:

The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program:

- (1) community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements;
- (2) community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and
- (3) community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Condition of Participation Level Deficiency	Standard Level Deficiency
<p>Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013</p> <p>Chapter 5 (CIES) 3. Agency Requirements</p> <p>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.</p> <p>Chapter 6 (CCS) 2. Service Requirements. E. The agency nurse(s) for Customized Community Supports providers must provide the following services: 1. Implementation of pertinent PCP orders; ongoing oversight and monitoring of the individual's health status and medically related supports when receiving this service;</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>I. Health Care Requirements for Family Living: 5. A nurse employed or contracted by the Family Living Supports provider must complete the e-CHAT, the Aspiration Risk Screening Tool, (ARST), and the</p>	<p>After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur.</p> <p>Based on record review, the Agency did not maintain the required documentation in the Individual's Agency Record as required by standard for 13 of 16 individual</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Electronic Comprehensive Health Assessment Tool (eCHAT) (#3, 5, 8, 10, 12, 14, 15) • Medication Administration Assessment Tool (#5, 8, 10, 12, 14, 15) • Comprehensive Aspiration Risk Management Plan: <ul style="list-style-type: none"> ➢ Not Found (#12,15) • Aspiration Risk Screening Tool (#5, 8, 10, 12, 14, 15) • Quarterly Nursing Review of HCP/Medical Emergency Response Plans: <ul style="list-style-type: none"> ◦ None found for 2/2014 - 1/2015 (#1) ◦ None found for 2/2014 - 1/2015 (#3) ◦ None found for 11/2014 - 1/2015 (#8) ◦ None found for 4/2014 – 12/2014 (#14) • Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans: 	<p>New / Repeat Finding:</p> <p>Based on record review, the Agency did not maintain the required documentation in the Individual's Agency Record as required by standard for 2 of 13 individual</p> <p>Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> • Quarterly Nursing Review of HCP/Medical Emergency Response Plans: <ul style="list-style-type: none"> ◦ None found for 2/2014 - 1/2015 (#1) • Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans: <ul style="list-style-type: none"> ◦ None found for 7/2014 - 9/2014 (#4) <i>(Note: Agency provided Nursing Reports for 3/2014 – 6/2014 and 10/2014 – 3/2015.)</i>

<p>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.</p> <p>a. For newly-allocated or admitted individuals, assessments are required to be completed within three (3) business days of admission or two (2) weeks following the initial ISP meeting, whichever comes first.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> ◦ None found for 6/2014 - 12/2014 (#4) ◦ None found for 4/2014 - 9/2014 (#11) • Special Health Care Needs: <ul style="list-style-type: none"> • <i>Nutritional Evaluation</i> <ul style="list-style-type: none"> ◦ Individual #10 - According to IST the individual is required to have an evaluation. No evidence of evaluation found. ◦ Individual #11 - According to IST the individual is required to have an evaluation. No evidence of evaluation found. ◦ Individual #14 - According to IST the individual is required to have an evaluation. No evidence of evaluation found. ◦ Individual #15 - According to IST the individual is required to have an evaluation. No evidence of evaluation found. • <i>Nutritional Plan</i> <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • Health Care Plans <ul style="list-style-type: none"> • <i>Aspiration</i> <ul style="list-style-type: none"> ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Body Mass Index</i> <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Constipation</i> 	
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<p>e. Develop any urgently needed interim Healthcare Plans or MERPs per DDS policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice.</p> <p>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 DDS Individual Case File Matrix policy.</p> <p>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:</p> <p>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 DDS 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;</p> <p>b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated;</p> <p>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</p> <p>d. Document for each individual that:</p> <p>i. The individual has a Primary Care Provider (PCP);</p>	<ul style="list-style-type: none"> ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Elevated Cholesterol</i> ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Falls</i> ◦ Individual #6 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>GERD</i> ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Hypertension</i> ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Respiratory</i> ◦ Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. 	
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<p>ii. The individual receives an annual physical examination and other examinations as specified by a PCP;</p> <p>iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist;</p> <p>iv. The individual receives a hearing test as specified by a licensed audiologist;</p> <p>v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and</p> <p>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).</p> <p>vii. The agency nurse will provide the individual's team with a semi-annual nursing report that discusses the services provided and the status of the individual in the last six (6) months. This may be provided electronically or in paper format to the team no later than (2) weeks prior to the ISP and semi-annually.</p> <p>f. The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards.</p> <p>Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: A. All assessments completed by the agency nurse, including the Intensive Medical Living Eligibility Parameters tool; for e-CHAT a printed copy of the current e-CHAT summary report shall suffice; F. Annual physical exams and annual dental exams (not applicable for short term stays);</p>	<ul style="list-style-type: none"> • <i>Seizures</i> Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Status of Care/Hygiene</i> ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • Medical Emergency Response Plans <ul style="list-style-type: none"> • <i>Allergies</i> ◦ Individual #6 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #11 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Aspiration</i> ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Diabetes</i> ◦ Individual #10 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Falls</i> ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the 	
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<p>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);</p> <p>H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements);</p> <p>I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange;</p> <p>J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay);</p> <p>L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay);</p> <p>O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays);</p> <p>P. Quarterly nursing summary reports (not applicable for short term stays);</p> <p>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.</p> <p>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.</p> <p>Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010</p> <p>F. The MERP shall be written in clear, jargon free language and include at a minimum the following information:</p>	<p>individual is required to have a plan. No evidence of a plan found.</p> <ul style="list-style-type: none"> ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Hypertension</i> <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Osteoporosis</i> <ul style="list-style-type: none"> ◦ Individual #8 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. • <i>Respiratory</i> <ul style="list-style-type: none"> ◦ Individual #8 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • <i>Seizures</i> <ul style="list-style-type: none"> ◦ Individual #5 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #15 - As indicated by the IST section of ISP the individual is required to have a plan. No evidence of a plan found. ◦ Individual #9 - According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. 	
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1. A brief, simple description of the condition or illness.
2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer.
3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia).
4. Clear, jargon free, step-by-step instructions regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911.
5. Emergency contacts with phone numbers.
6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located.

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

CHAPTER 1 II. PROVIDER AGENCY

REQUIREMENTS: D. Provider Agency Case File for the Individual: All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements...1, 2, 3, 4, 5, 6, 7, 8,

CHAPTER 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION - Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services: Chapter 1. III. E. (1 - 4) (1) Documentation of nursing assessment

<p>activities (2) Health related plans and (4) General Nursing Documentation</p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p>CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination</p> <p>(2) Coordinate with the IDT to ensure that each individual participating in Community Inclusion Services who has a score of 4, 5, or 6 on the HAT has a Health Care Plan developed by a licensed nurse, and if applicable, a Crisis Prevention/Intervention Plan.</p>		
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Standard of Care	Routine Survey Deficiencies March 23 – 26, 2015	Verification Survey New and Repeat Deficiencies February 23 – 24, 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 # 1A08.1 Agency Case File - Progress Notes	Standard Level Deficiency	COMPLETED
Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	Standard Level Deficiency	COMPLETED
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	COMPLETED
Tag # 1A20 Direct Support Personnel Training	Standard Level Deficiency	COMPLETED
Tag # 1A37 Individual Specific Training	Standard Level Deficiency	COMPLETED
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 # 1A09 Medication Delivery Routine Medication Administration	Standard Level Deficiency	COMPLETED
Tag # 1A27 Incident Mgt. Late and Failure to Report	Standard Level Deficiency	COMPLETED
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Standard Level Deficiency	COMPLETED
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 # IS25 / 5I25 Community Integrated Employment Services / Supported Employment Reimbursement	Standard Level Deficiency	COMPLETED

Date: September 28, 2016

To: Matthew Bardwell, Director
Provider: Connections LLC
Address: 217 San Pedro Drive NE
State/Zip: Albuquerque, New Mexico 87108

E-mail Address: admin@connectionsnm.com

Region: Metro
Routine Survey: March 23 - 26, 2015
Verification Survey: February 23 – 24, 2016
Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: **2012: Inclusion Supports** (Customized Community Supports, Community Integrated Employment Services)
2007: Community Inclusion (Adult Habilitation, Community Access, Supported Employment)

Survey Type: Verification

Dear Mr. Bardwell;

The Division of Health Improvement/Quality Management Bureau has received and reviewed the supporting documents you submitted for your Plan of Correction.

The Plan of Correction process with the Quality Management Bureau is now complete, however, your case remains open with the Internal Review Committee.

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.

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.16.3.DDW.D0178.5.VER.09.16.272