Date:	May 10, 2017
To:	Karan Sangha, Director of Operations
Provider:	The New Beginnings, LLC
Address:	8908 Washington Street, NE
State/Zip:	Albuquerque, New Mexico 87113
E-mail Address:	ksangha@tnbabq.com
CC:	Diane Dahl-Nunn, Executive Director
Address:	8908 Washington Street, NE
State/Zip:	Albuquerque, New Mexico 87113
E-Mail Address	dnunn@tnbabq.com
Region:	Metro
Routine Survey:	March 14 – 29, 2016
Verification Survey:	March 31 – April 5, 2017
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living, Family Living, Intensive Medical Living); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports ***2007:*** *Community Living* (Supported Living, Family Living, Independent Living) and *Community Inclusion* (Adult Habilitation)
Survey Type:	Verification
Team Leader:	Deb Russell, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Tricia Hart, AAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Anthony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality Management Bureau; Christopher Melon, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Barbara Kane, BAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau and Kandis Gomez, AA, Division of Health Improvement/Quality Management Bureau

Dear Mr. Sangha;

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 14 – 29, 2016*.

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

Compliance with Conditions of Participation.

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

Plan of Correction:

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

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

Submission of your Plan of Correction:

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

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

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

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

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

Sincerely,

Deb Russell

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

Survey Process Employed:

Administrative Review Start Date:	March 31, 2017
Contact:	**The New Beginnings, LLC** Diane Dahl-Nunn, Executive Director **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor
Entrance Conference Date:	April 3, 2017
Present:	**The New Beginnings, LLC** Diane Dahl-Nunn, Executive Director Kelley Krinke, Director of Supported Living/Service Coordinator Rochelle Chisolm, Director of Nursing Jacqueline Bobo, Human Resources **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Kandis Gomez, AA, Healthcare Surveyor Lora Norby, Healthcare Surveyor Barbara Kane, BAS, Healthcare Surveyor
Exit Conference Date:	April 5, 2017
Present:	**The New Beginnings, LLC** Diane Dahl-Nunn, Executive Director Jacqueline Bobo, Human Resources Rochelle Chisolm, RN, Director of Nursing Janine Holguin, Nurse Kelley Krinke, Director of Supported Living / Service Coordinator Dan Davis, Service Coordinator Terri Corrao, Service Coordinator Annette Moya, Service Coordinator Molli D. Bass, Service Coordinator Chris Heimerl, Monitor **DOH/DHI/QMB** Deb Russell, BS, Team Lead/Healthcare Surveyor Lora Norby, Healthcare Surveyor Barbara Kane, BAS, Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager **DDSD - METRO Regional Office** Jason Cornwell, Assistant Director Michael Driskell, Assistant Director Anna Zollinger, Community Inclusion Coordinator
Administrative Locations Visited	Number: 1
Total Sample Size	Number: 40 5 - *Jackson* Class Members 35 - Non-*Jackson* Class Members 16 - Supported Living 17 - Family Living

		1 - Intensive Medical Living Supports 1 - Independent Living 4 - Adult Habilitation 14 - Customized Community Supports 4 - Customized In-Home Supports
Total Homes Visited	Number:	12
❖ Supported Living Homes Visited	Number:	8 *Note: The following Individuals share a SL residence:* ➢ #8, 14, 47 ➢ #13, 33, 36 ➢ #30, 46
❖ Family Living Homes Visited	Number:	4
Persons Served Records Reviewed	Number:	40
Direct Support Personnel Records Reviewed	Number:	250
Direct Support Personnel Interviewed during Verification Survey	Number:	0
Direct Support Personnel Interviewed during Routine Survey	Number:	48
Substitute Care/Respite Personnel	Number:	49
Service Coordinator Records Reviewed	Number:	6

Administrative Processes and Records Reviewed:

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

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

Attachment B

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

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

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

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

The Determination of Compliance for each service type is based on a provider's compliance with CoPs in the following Service Domains.

Case Management Services *(Four Service Domains)*:

- Plan of Care: ISP Development & Monitoring
- Level of Care
- Qualified Providers
- Health, Safety and Welfare

Community Living Supports / Inclusion Supports *(Three Service Domains)*:

- Service Plans: ISP Implementation
- Qualified Provider
- Health, Safety and Welfare

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 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: Plan of Care ISP Development & Monitoring

Condition of Participation:

1. **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:

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

Service Domain: Level of Care

Condition of Participation:

3. **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.

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: Service Plan: ISP Implementation

Condition of Participation:

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

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 and/or 6 or more Condition of Participation level deficiencies overall, as well as widespread Standard level deficiencies identified in the attached QMB Report of Findings and requires implementation of a Plan of Correction.

This non-compliance, if not corrected, may result in a serious negative outcome or the potential for more than minimal harm to individuals' health and safety. The agency may also have Standard level deficiencies (deficiencies which are not at the condition level) in any of the Service Domains

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

Attachment C

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

Introduction:

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

Instructions:

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

The following limitations apply to the IRF process:

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

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

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

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

Agency: **The New Beginnings, LLC - Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living, Family Living, Intensive Medical Living Services); *Inclusion Supports* (Customized Community Supports) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Supported Living, Family Living, Independent Living) and *Community Inclusion* (Adult Habilitation)
Monitoring Type: Verification Survey
Survey Date: **March 14 – 29, 2016**
Verification Survey: **March 31 – April 5, 2017**

Standard of Care	Routine Survey Deficiencies March 14 – 29, 2016	Verification Survey New and Repeat Deficiencies March 31 – April 5, 2017
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # LS14 / 6L14 **Residential Case File**	**Standard Level Deficiency**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 12 (SL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 13 (IMLS) 2. Service Requirements** **B.1. Documents To Be Maintained In The Home:** a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access;	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 27 of 32 Individuals receiving Family Living Services, Supported Living Services and Intensive Medical Living Supports. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ◦ None Found (#2, 13, 17, 39, 41) ◦ Did not contain Pharmacy Information (#19, 21, 28) ◦ Did not contain Health Plan (Insurance; Medicaid, Medicare, etc.) (#25, 28, 34) • Annual ISP (#7, 14)	**Repeat Finding:** Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 3 of 40 Individuals receiving Family Living Services, Supported Living Services and Intensive Medical Living Supports. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • Speech Therapy Plan (#26, 34) • Occupational Therapy Plan (#22, 34)

b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable; d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website; g. Medication Administration Records for the current month; h. Record of medical and dental appointments for the current year, or during the period of stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.	• Individual Specific Training Section of ISP (formerly Addendum B) (#7, 14) • **ISP Teaching and Support Strategies** ◦ *Individual #22 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "…will choose a cake to make." ➢ "…will improve her decorating skills with cake. ◦ Live Outcome Statement: ➢ "…will research an ingredient to make lip balm." ◦ *Individual #36 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "Will add the ingredients to blender." ➢ "Will blend the ingredients." ➢ "Will pour the smoothie into a glass." ◦ Fun Outcome Statement: ➢ "Will participate in practice and events" ◦ Individual #38 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "Will need assistance to participate in the exercise." ◦ Individual #40 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "I will put my clothes in the washer and dryer." ◦ Fun Outcome Statement: ➢ "[sic] I will plan an activity of his choice with a friend of his choice."	

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders;	➢ "I will attend the activity." • Positive Behavioral Plan (#7, 22, 30, 33) • Behavior Crisis Intervention Plan (#7, 30, 33) • Speech Therapy Plan (#9, 13, 14, 23, 26, 34, 36, 37) • Occupational Therapy Plan (#14, 15, 22, 26, 34, 41) • Physical Therapy Plan (#15, 26) • Healthcare Passport (#2, 7, 8, 14, 15, 17, 21, 22, 25, 28, 34) • **Special Health Care Needs** ◦ Comprehensive Aspiration Risk Management Plan: ➢ Not Found (#26) ➢ Not Current (#9, 23, 36) ◦ Nutritional Plan (#7, 29, 34) • **Health Care Plans** ◦ Aspiration (#26, 36) ◦ Body Mass Index (#5, 15, 21, 22) ◦ Bowel and Bladder (#26) ◦ Chronic Obstructive Pulmonary Disorder (#30) ◦ Colostomy (#5) ◦ Communication/Vision/Hearing (able to make needs known) (#26) ◦ Constipation (#13, 39)	

(8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioner's prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult	◦ Diabetes (#13) ◦ G-tube (#15, 26) ◦ Health issues prevented desired level of participation (#26) ◦ Hypothyroid (#11) ◦ Incontinence (#15) ◦ Infectious process (#30) ◦ Neuro Device and Implants (#21, 34) ◦ Oral Care (#22) ◦ Pain (#15) ◦ Reflux (#36) ◦ Seizures (#15) ◦ Skin Integrity (#15) ◦ Sleep Apnea (#2) ◦ Trach Tube Care (#15) ◦ Utilization of PRN Psychoactive Medication (#5) ◦ Vasovagal Syncope (#2) • **Medical Emergency Response Plans** ◦ Aspiration (#13, 15) ◦ Chronic Obstructive Pulmonary Disorder / Respiratory (#30) ◦ Deep Brain Stimulator (#15)	

health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.	◦ Diabetes (#13) ◦ Gastrointestinal (#26, 38) ◦ High Blood Pressure (#21) ◦ Neuro Device and Implants (#21, 34) ◦ Pain (#15) ◦ Respiratory (#2, 15, 26, 34) ◦ Tube Feeding (#15) ◦ Vasovagal Syncope (#2) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #7 - None found for 3/1 – 15, 2016. ◦ Individual #25 - None found for 3/1 – 15, 2016. ◦ Individual #33 - None found for 3/6/2016. ◦ Individual #34 - None found for 3/5, 13, 2016. ◦ Individual #38 – None found for 3/1, 16, 2016. • **Progress Notes written by DSP and/or Nurses regarding Health Status:** ◦ Individual #41 - None found for 3/1 - 16, 2016 • **Record of visits of healthcare practitioners** (#7, 8, 11, 14, 25, 41)	

Standard of Care	Deficiencies	Verification Survey New and Repeat Deficiencies March 31 – April 5, 2017
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A22 **Agency Personnel Competency**	**Condition of Participation Level Deficiency**	**Standard Level Deficiency**
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy;	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on interview, the Agency did not ensure training competencies were met for 10 of 48 Direct Support Personnel. **When DSP were asked if the Individual had a Positive Behavioral Supports Plan and if so, what the plan covered, the following was reported:** • DSP #231 stated, "I don't have any idea what this is." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #9) • DSP #239 stated, "I don't think so." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #10) • DSP #401 stated, "I'm not sure." According to the Individual Specific Training Section of the ISP, the Individual requires a Positive Behavioral Supports Plan. (Individual #5) **When DSP were asked if the individual had a Positive Behavioral Crisis Plan and if so, what the plan covered, the following was reported:**	**Repeat Finding:** Based on record review, the Agency did not ensure retraining on Individual Specific Training competencies were met for 1 of 48 Direct Support Personnel. No documentation was provided for DSP #401 for retraining on the Health Care Plans. The following training competencies were not found for DSP #401: • **Health Care Plans:** ◦ Individual #5 ▪ Body Mass Index ▪ Status of care/hygiene ▪ Colostomy/ileostomy ▪ Utilization of PRN psychoactive medication

CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements: The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements.	• DSP #204 stated, "I don't think so." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #13) • DSP #231 stated, "I don't have any idea what this is." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #9) • DSP #239 stated, "I don't think so." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #10) • DSP #443 stated, "She does not have one at this time." According to the Individual Specific Training Section of the ISP, the individual has Positive Behavioral Crisis Plan. (Individual #24) **When DSP were asked if the individual requires a physical restraint, such as MANDT, CPI, Handle with Care, and if so, have they been trained to perform these safely:** • DSP #429 stated, "CPI, but I've never been trained on CPI." According to the Individual's Positive Behavioral Crisis Plan, CPI is to be used. (Individual #39) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #231 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #9) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the plan covered, the following was reported:**	

B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information about the individual's preferences with regard to privacy, communication	• DSP #204 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #13) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #204 stated, "Aspiration, endocrine, constipation." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Health Care Plan for: status of care/hygiene. (Individual #13) • DSP #247 stated, "Aspiration and GERD." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires a Health Care Plan for: Body mass index. (Individual #36) • DSP #231 stated, "I don't know if he does." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Aspiration risk and seizures. (Individual #9) • DSP #340 stated, "I don't know. Has one for seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires a Health Care Plan for Aspiration risk. (Individual #9) • DSP #401 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Body Mass Index, status of care/hygiene, colostomy/ileostomy, and utilization of PRN psychoactive meds. (Individual #5) • DSP #413 stated, "Molina." As indicated by the Electronic Comprehensive Health Assessment	

style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific. training whenever possible. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;	Tool, the Individual requires Health Care Plans for: Body Mass Index and Respiratory. (Individual #20) • DSP #435 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for: Constipation. (Individual #38) **When DSP were asked if the Individual had Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #204 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans: aspiration risk and endocrine. (Individual #13) • DSP #231 stated, "I don't know if he does." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans: aspiration risk, allergies and seizures. (Individual #9) • DSP #340 stated, "I don't know. Has one for seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual additionally requires a Medical Emergency Response Plan for: aspiration risk. (Individual #9) • DSP #413 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for: Respiratory. (Individual #20) • DSP #443 stated, "No." As indicated by the Individual Specific Training section of the ISP indicates the Individual requires a Medical Emergency Response Plan for: Blood Clots. (Individual #24)	

	When DSP were asked if the Individual had a Seizure Disorder, and if they had been trained on Seizures, the following was reported: • DSP #231 stated, "I have not been to any trainings for seizures, I just know what to do." As indicated by the Individual Specific Training section of the ISP Day staff are required to receive training. (Individual #9)	

Standard of Care	Deficiencies	Verification Survey New and Repeat Deficiencies March 31 – April 5, 2017
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A27.2 **Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider**	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 7.1.14 ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS **NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS:** **A. Duty to report:** **(1)** All community-based providers shall immediately report alleged crimes to law enforcement or call for emergency medical services as appropriate to ensure the safety of consumers. **(2)** All community-based service providers, their employees and volunteers shall immediately call the department of health improvement (DHI) hotline at 1-800-445-6242 to report abuse, neglect, exploitation, suspicious injuries or any death and also to report an environmentally hazardous condition which creates an immediate threat to health or safety. **B. Reporter requirement.** All community-based service providers shall ensure that the employee or volunteer with knowledge of the alleged abuse, neglect, exploitation, suspicious injury, or death calls the division's hotline to report the incident. **C. Initial reports, form of report, immediate action and safety planning, evidence preservation, required initial notifications: (1) Abuse, neglect, and exploitation, suspicious injury or death reporting:** Any person may report an	Based on record review, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 1 of 40 Individuals. During the on-site survey March 14, 2016, surveyors observed the following: During the on-site visit, a surveyor discovered a medical consultation form generated by The New Beginnings which read, "Pt observed in ED after accidental drug ingestion. Poison Control consulted. No further observation in ED required." This incident was not reported to DHI for neglect. As a result of what was observed the following incident(s) was reported: Individual #33 • A State Incident Report of Neglect was filed on March 14, 2016. Incident report was reported to DHI.	**New Finding:** Based on observation and interview, the Agency did not report suspected abuse, neglect, or exploitation**,** unexpected and natural/expected deaths; or other reportable incidents to the Division of Health Improvement for 4 of 40 Individuals. During the on-site survey, April 3, 2017 at 4:00 pm, surveyors observed the following: During the on-site survey, the surveyors completed a Health and Safety check of 5 apartments which were located within the same complex. Upon observations of the apartments Surveyors found four of the five apartments (Individual #30, 44, 45, 46) had no food in the refrigerators, cabinets and pantries. *Note: Individuals #30 and 46 share a residence.* When Surveyors asked the Direct Service Personnel about the lack of food in the apartments, it was reported that all food was kept locked in the common food storage area. During interviews, Individual #45 reported to Surveyors that food is not allowed in the home because two years ago the Individual had thrown food all over the house. However, (House Lead) indicated that Individual #45 may have the food the individual purchases with their food stamps or their

allegation of abuse, neglect, or exploitation, suspicious injury or a death by calling the division's toll-free hotline number 1-800-445-6242. Any consumer, family member, or legal guardian may call the division's hotline to report an allegation of abuse, neglect, or exploitation, suspicious injury or death directly, or may report through the community-based service provider who, in addition to calling the hotline, must also utilize the division's abuse, neglect, and exploitation or report of death form. The abuse, neglect, and exploitation or report of death form and instructions for its completion and filing are available at the division's website, http://dhi.health.state.nm.us, or may be obtained from the department by calling the division's toll free hotline number, 1-800-445-6242. **(2) Use of abuse, neglect, and exploitation or report of death form and notification by community-based service providers:** In addition to calling the division's hotline as required in Paragraph (2) of Subsection A of 7.1.14.8 NMAC, the community-based service provider shall also report the incident of abuse, neglect, exploitation, suspicious injury, or death utilizing the division's abuse, neglect, and exploitation or report of death form consistent with the requirements of the division's abuse, neglect, and exploitation reporting guide. The community-based service provider shall ensure all abuse, neglect, exploitation or death reports describing the alleged incident are completed on the division's abuse, neglect, and exploitation or report of death form and received by the division within 24 hours of the verbal report. If the provider has internet access, the report form shall be submitted via the division's website at http://dhi.health.state.nm.us; otherwise it may be submitted via fax to 1-800-584-6057. The community-based service provider shall ensure that the reporter with the most direct knowledge of the incident participates in the preparation of the report form.		own money in the refrigerator. In response, Individual #45 reported the Individual is not allowed to have food in the apartment. Individual #45 reported anything placed in the refrigerator is taken out and locked up. As a result of what was observed and reported the following incident was reported: Individuals #30, 44, 45, 46 • A State Incident Report of Neglect was filed on April 4, 2017. Incident report was reported to DHI.

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

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

Tag # 1A31 Client Rights/Human Rights	N/A	Standard Level Deficiency
7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01] **Long Term Services Division** **Policy Title: Human Rights Committee Requirements Eff Date: March 1, 2003** **IV. POLICY STATEMENT -** Human Rights Committees are required for residential service		**New Finding:** Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 40 Individuals. A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • No door to bedroom or bathroom - (Individual #5) No evidence found of Human Rights Committee approval. • No dry goods in home, locked in common food cabinet in garage. No evidence found of Human Rights Committee approval. (Individual #30)

provider agencies. The purpose of these committees with respect to the provision of Behavior Supports is to review and monitor the implementation of certain Behavior Support Plans. Human Rights Committees may not approve any of the interventions specifically prohibited in the following policies: • Aversive Intervention Prohibitions • Psychotropic Medications Use • Behavioral Support Service Provision. A Human Rights Committee may also serve other agency functions as appropriate, such as the review of internal policies on sexuality and incident management follow-up. **A. HUMAN RIGHTS COMMITTEE ROLE IN BEHAVIOR SUPPORTS** Only those Behavior Support Plans with an aversive intervention included as part of the plan or associated Crisis Intervention Plan need to be reviewed prior to implementation. Plans not containing aversive interventions do not require Human Rights Committee review or approval. 2. The Human Rights Committee will determine and adopt a written policy stating the frequency and purpose of meetings. Behavior Support Plans approved by the Human Rights Committee will be reviewed at least quarterly. 3. Records, including minutes of all meetings will be retained at the agency with primary responsibility for implementation for at least five years from the completion of each individual's Individual Service Plan. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:**		

Medication Assessment and Delivery Procedure Eff Date: November 1, 2006 **B. 1. e.** If the PRN medication is to be used in response to psychiatric and/or behavioral symptoms in addition to the above requirements, obtain current written consent from the individual, guardian or surrogate health decision maker and submit for review by the agency's Human Rights Committee (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications).		

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit; e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; g. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 18 of 28 Supported Living, Family Living and Intensive Medical Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 117^0 F (#5) ➢ Water temperature in home measured 132.1^0 F (#8, 14) ➢ Water temperature in home measured 112.5^0 F (#15) ➢ Water temperature in home measured 118.9^0 F (#23) ➢ Water temperature in home measured 143.4^0 F (#29) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#8, 14) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address,	**Repeat Finding:** Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 2 of 12 Supported Living, Family Living and Intensive Medical Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not functioning or incomplete: **Supported Living Requirements:** • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 115.6^0 F (#15) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5) *Note: The following Individuals shared a SL residence:* ➢ *8, 14, 47* ➢ *13, 33, 36* ➢ *30, 46*

consistent with the Assisting with Medication Delivery training or each individual's ISP; and h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports- Supported Living Services:** 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water, and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Ensure water temperature in home does not exceed safe temperature (110^0 F); d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system; e. Have a general-purpose First Aid kit;	but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#5, 30, 34) **Family Living Requirements:** • Battery operated or electric smoke detectors, heat sensors, or a sprinkler system installed in the residence (#38) • General-purpose first aid kit (#7) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#11, 12, 17, 18, 41) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#4, 19, 21, 40, 41) *Note: The following Individuals shared a SL residence:* ➢ *8, 14* ➢ *13, 33, 36*	

f. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; g. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year. For Supported Living evacuation drills must occur at least once a year during each shift; h. Have accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and i. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 13 (IMLS) 2. Service Requirements R. Staff Qualifications: 3. Supervisor Qualifications and Requirements:** S Each residence shall include operable safety equipment, including but not limited to, an operable smoke detector or sprinkler system, a carbon monoxide detector if any natural gas appliance or heating is used, fire extinguisher, general purpose first aid kit, written procedures for emergency evacuation due to fire or other emergency and documentation of evacuation drills occurring at least annually during each shift, phone number for poison control within line of site of the telephone, basic utilities, general household appliances, kitchen and dining utensils, adequate food and drink for three meals		

per day, proper food storage, and cleaning supplies. T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home. U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions. V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **L. Residence Requirements for Family Living Services and Supported Living Services**		

Standard of Care	Routine Survey Deficiencies March 14 – 29, 2016	Verification Survey New and Repeat Deficiencies March 31 – April 5, 2017
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A08 Agency Case File	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A08.1 Agency Case File - Progress Notes	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # IS11 / 5I11 Reporting Requirements Inclusion Reports	**Standard Level Deficiency**	**COMPLETE**
Tag # LS17 / 6L17 Reporting Requirements (Community Living Reports)	**Standard Level Deficiency**	**COMPLETE**
Tag # IH17 Reporting Requirements (Customized In-Home Supports Reports)	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A20 Direct Support Personnel Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A25 Criminal Caregiver History Screening	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A28.1 Incident Mgt. System - Personnel Training	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A08.2 Healthcare Requirements	**Condition of Participation Level Deficiency**	**COMPLETE**

Tag # 1A03 CQI System	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A29 Complaints / Grievances Acknowledgement	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A33.1 Board of Pharmacy – License	**Standard Level Deficiency**	**COMPLETE**
Tag # LS06 / 6L06 Family Living Requirements	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # 5I44 Adult Habilitation Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # IS30 Customized Community Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 / 6L26 Supported Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # IM31 Intensive Medical Living Services Reimbursement	**Standard Level Deficiency**	**COMPLETE**
Tag # IH32 Customized In-Home Supports Reimbursement	**Standard Level Deficiency**	**COMPLETE**

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

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag # 1A27.2 **Duty to Report IRs Filed During On-Site and/or IRs Not Reported by Provider**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A31 **Client Rights/Human Rights**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Date: June 8, 2017

To: Karan Sangha, Director of Operations
Provider: The New Beginnings, LLC
Address: 8908 Washington Street, NE
State/Zip: Albuquerque, New Mexico 87113

E-mail Address: ksangha@tnbabq.com

CC: Diane Dahl-Nunn, Executive Director
Address: 8908 Washington Street, NE
State/Zip: Albuquerque, New Mexico 87113

E-Mail Address dnunn@tnbabq.com

Region: Metro
Routine Survey: March 14 – 29, 2016
Verification Survey: March 31 – April 5, 2017
Program Surveyed: Developmental Disabilities Waiver

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

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

Survey Type: Verification

Dear Mr. Sangha;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

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