Date:	October 6, 2016
To:	Lisa Swanson, Executive Director
Provider: Address: State/Zip:	Southwest Services for the Deaf, Inc. 2202 Menual Boulevard NE #2 Albuquerque, New Mexico 87107
Mailing Address:	3301 R Coors Road NW Suite 265 Albuquerque, New Mexico 87120
E-mail Address:	lisaswsd@gmail.com
Region: Routine Survey: Verification Survey:	Metro April 25 – 28, 2016 September 2 – 7, 2016 & September 26 – 29, 2016
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Inclusion Supports* (Customized Community Supports)
Survey Type:	Verification
Team Leader:	Kandis Gomez, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Members:	Nicole Brown, MBA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Swanson:

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 April 25 - 28, 2016*.

Determination of Compliance:

The Division of Health Improvement, Quality Management Bureau has determined your agency remains to be in:

Non-Compliance with Conditions of Participation

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

- Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation
- Tag # 1A22 Agency Personnel Competency
- Tag # 1A28.2 Incident Management System – Parent/Guardian Training
- Tag # 1A29 Complaints / Grievances – Acknowledgement

Due to the new/repeat condition level deficiencies your agency will be referred to the Internal Review Committee (IRC). Your agency will also 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,

Kandis Gomez, AA

Kandis Gomez, AA
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Entrance Conference Date:	September 6, 2016	
Present:	**Southwest Services for the Deaf, Inc.** Lisa Swanson, Executive Director / Service Coordinator Tupper Dunbar, DDSD Trainer Deaf Service Specialist **DOH/DHI/QMB** Kandis Gomez, AA, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor	
Exit Conference Date:	September 7, 2016	
Present:	**Southwest Services for the Deaf, Inc.** Lisa Swanson, Executive Director / Service Coordinator Sophia Pacias, Direct Service Professional Tamela Hedgpeth, Interpreter **DOH/DHI/QMB** Kandis Gomez, AA, Team Lead/Healthcare Surveyor Nicole Brown, MBA, Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	4 0 - *Jackson* Class Members 4 - Non-*Jackson* Class Members 4 - Customized Community Supports
Persons Served Records Reviewed	Number:	4
Direct Support Personnel Records Reviewed	Number:	4
Service Coordinator Records Reviewed	Number:	1 (*Executive Director also performs duties as Service Coordinator*)

Administrative Processes and Records Reviewed:

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

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

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 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: 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: **Southwest Services for the Deaf, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Inclusion Supports* (Customized Community Supports)
Monitoring Type: Verification Survey
Routine Survey: **April 25 – 28, 2016**
Verification Survey: **September 2 – 7, 2016**

Standard of Care	Routine Survey Deficiencies April 25 – 28, 2016	Verification Survey New and Repeat Deficiencies September 2 –7, 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 # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 4 individuals. As indicated by Individuals' ISP, the following were found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will actively participate in group discussion regarding scheduling activities for	**New/Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 4 individuals. As indicated by Individuals' ISP, the following were found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will actively participate in group discussion regarding scheduling activities for

division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	participation in" for 1/2016 – 3/2016. Action step is to be completed monthly. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will choose one activity for the group to participate in" for 1/2016 – 3/2016. Action step is to be completed monthly. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will learn appropriate social greetings/basics on friendship building while in the community" for 1/2016 – 3/2016. Action step is to be completed weekly. Individual #2 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will attend and complete one quarter at CNM" for 1/2016 – 3/2016. Action step is to be completed 1 – 2 times a week. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will complete homework" for 1/2016 – 3/2016. Action step is to be completed 1 – 2 times a week. Individual #3 • None found regarding for 1/2016 – 3/2016. *Note: No ISP was found to indicate the outcome / action steps and the frequency to which those outcome / action steps were to be completed.* Individual #4 • None found regarding: Live Outcome/Action Step: "…with staff prompts, will practice locking his home door" for	participation in" for 7/2016 – 8/2016. Action step is to be completed monthly. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will choose one activity for the group to participate in" for 7/2016 – 8/2016. Action step is to be completed monthly. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will learn appropriate social greetings/basics on friendship building while in the community" for 7/2016 – 8/2016. Action step is to be completed weekly. Individual #2 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will attend and complete one quarter at CNM" for 7/2016 – 8/2016. Action step is to be completed 1 – 2 times a week. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will complete homework" for 7/2016 – 8/2016. Action step is to be completed 1 – 2 times a week. Individual #3 • None found for 7/2016 – 8/2016. Individual #4 • None found regarding: Live Outcome/Action Step: "…with staff prompts, will practice locking his home door" for 7/2016 – 8/2016. Action step is to be completed 2 times a week.

	1/2016 – 3/2016. Action step is to be completed 2 times a week.	

Standard of Care	Routine Survey Deficiencies April 25 – 28, 2016	Verification Survey New and Repeat Deficiencies September 2 –7, 2016
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A22 **Agency Personnel Competency**	**Condition of Participation Level Deficiency**	**Condition of Participation 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:	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 1 of 1 Direct Support Personnel. **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #200 stated, "I'm not sure." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #1) • DSP #200 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #2) • DSP #200 stated, "No." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #4) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:**	**Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review and interview, the Agency did not fully implement the Plan of Correction to ensure training competencies were met for 1 of 1 Direct Support Personnel. As stated in the Plan of Correction approved on July 12, 2016, "ISP plans have been placed into the individual's binders (files) for staff access. Service coordinator will schedule training/re-training for the staff." When Executive Director / Service Coordinator #202 was asked for evidence DSP #200 had received training on the following required plans Executive Director / Services Coordinator #202 stated, "The nurse was out of town and she would train them when she got back." The following training competencies were not found for DSP #200: • **Health Care Plans:** ◦ Individual #1 ▪ Constipation ◦ Individual #2 ▪ Allergies ▪ Asthma/Respiratory ▪ Communication

Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the	• DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Aspiration Risk, Status of Care/Hygiene, Seizure Disorder, Constipation and Respiratory. (Individual #1) • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Allergies, Nutrition, Communication, Vision, Asthma, Psychoactive Medication and Respiratory. (Individual #2) • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Asthma/Respiratory Distress/Nebulizer Use. (Individual #3) • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Falls. (Individual #4) **When DSP were asked if the Individual had a Medical Emergency Response Plans and if so, what the plan(s) covered, the following was reported:** • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration Risk, Seizure Disorder and Respiratory. (Individual #1) • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires	▪ Nutrition ▪ Psychoactive Medication ▪ Vision • **Medical Emergency Response Plans:** ◦ Individual #1 ▪ Aspiration Risk ◦ Individual #2 ▪ Respiratory/Asthma ▪ Psychoactive Medications

state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B. Individual specific training must be arranged and conducted, including training on the Individual Service Plan outcomes, actions steps and strategies and associated support plans (e.g. health care plans, MERP, PBSP and BCIP etc.), information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has 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	Medical Emergency Response Plans for Respiratory/Asthma and Psychoactive Medications. (Individual #2) • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Asthma/Respiratory Distress/Nebulizer Use. (Individual #3) • DSP #200 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Falls and Bowel and Bladder/Incontinence. (Individual #4) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #200 stated, "Hearing Loss." According to the individual's ISP and Electronic Comprehensive Health Assessment Tool, the individual is diagnosed with Cerebral Palsy, Epilepsy, Moderate ID, Seizure Disorder, Pedophilia, Post Traumatic Stress Disorder, Reactive Attachment Disorder, and right sided Hemiplegia. DSP did not discuss the listed diagnosis. (Individual #1) • DSP #200 stated, "Deaf." According to the individual's ISP and Electronic Comprehensive Health Assessment Tool, the individual is additionally diagnosed with Asthma, Depression, Diabetes, Hypertension, Hypothyroidism, Moderate Intellectual Disability, and Reflux/GERD. DSP did not discuss the listed diagnosis. (Individual #2) • DSP #200 stated, "Deafness." According to the individual's ISP and Electronic Comprehensive Health Assessment Tool, the individual is diagnosed with Mild Intellectual Disability,	

specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc.), and information about the individual's preferences with regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERP, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Supported Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 13 (IMLS) R. 2. Service Requirements. Staff Qualifications 2. DSP Qualifications.** E. Complete training requirements as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff - effective March 1, 2007. Report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy;	Asthma, Sleep Apnea, Osteopenia, Presbyopia, Reflux/GERD, Scoliosis, Myopathy non-inflammatory and fixed deformity (Kyphosis/Scoliosis). DSP did not discuss the listed diagnosis. (Individual #3) • DSP #200 stated, "Deafness." According to the individual's ISP and Electronic Comprehensive Health Assessment Tool, the individual is diagnosed with Mild Intellectual Disability and Cerebral Palsy. DSP did not discuss the listed diagnosis. (Individual #4) **When DSP were asked if the Individual had any food and/or medication allergies that could be potentially life threatening, the following was reported:** • DSP #200 stated, "No." As indicated by Electronic Comprehensive Health Assessment Tool, the individual is allergic to Penicillin and Dried Apricots. (Individual #3)	

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	Condition of Participation Level Deficiency	Standard Level Deficiency
NMAC 7.1.12.8 REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 3 Agency Personnel. **The following Agency personnel records contained no evidence of the Employee Abuse Registry check being completed:** **Direct Support Personnel (DSP):** • #201 – Date of hire 7/10/2015. **Service Coordination Personnel (SC):** • #202 – Date of hire 8/15/2010.	**New/Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 2 of 5 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #203 – Date of hire 4/26/2016, completed 5/4/2016. • #204 – Date of hire 5/2/2016, completed 5/4/2016.

custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.		

Tag # 1A36 Service Coordination Requirements	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: K. In addition to the applicable requirements described in policy statements B – I (above), direct support staff, direct support supervisors, and internal service coordinators shall complete DDSD-approved core curriculum training. Attachments A and B to this policy identify the specific competency requirements for the following levels of core curriculum training: 1. Introductory Level – must be completed within thirty (30) days of assignment to his/her position with the agency. 2. Orientation – must be completed within ninety (90) days of assignment to his/her position with the agency. 3. Level I – must be completed within one (1) year of assignment to his/her position with the agency. **NMAC 7.26.5.7** "service coordinator": the community provider staff member, sometimes called the program manager or the internal case manager, who supervises, implements and monitors the service plan within the community service provider agency **NMAC 7.26.5.11** (b) service coordinator: the service coordinators of the community provider agencies shall assure that appropriate staff develop strategies specific to their responsibilities in the ISP; the service coordinators shall assure the action plans and strategies are implemented consistent with the provisions of the ISP, and shall report to the case manager on ISP implementation and the	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure that Orientation and Training requirements were met for 1 of 1 Service Coordinators. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Part One (SC #202) • Pre-Service Part Two (SC #202) • Person Centered Planning (2-Day) (SC #202) • Promoting Effective Teamwork (SC #202) • Advocacy Strategies (SC #202) • Level 1 Health (SC #202)	**Repeat Finding:** Based on record review, the Agency did not fully implement the Plan of Correction to ensure that Orientation and Training requirements were met. Review of Service Coordinators training records found no evidence of the following required DOH/DDSD trainings being completed: • Pre-Service Part One (SC #202) • Pre-Service Part Two (SC #202)

individual's progress on action plans within their agencies; for persons funded solely by state general funds, the service coordinator shall assume all the duties of the independent case manager described within these regulations; if there are two or more "key" community service provider agencies with two or more service coordinator staff, the IDT shall designate which service coordinator shall assume the duties of the case manager; the criteria to guide the IDTs selection are set forth as follows: (i) the designated service coordinator shall have the skills necessary to carry out the duties and responsibilities of the case manager as defined in these regulations; (ii) the designated service coordinator shall have the time and interest to fulfill the functions of the case manager as defined in these regulations; (iii) the designated service coordinator shall be familiar with and understand community service delivery and supports; (iv) the designated service coordinator shall know the individual or be willing to become familiar and develop a relationship with the individual being served;		

Standard of Care	Routine Survey Deficiencies April 25 – 28, 2016	Verification Survey New and Repeat Deficiencies September 2 –7, 2016
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag #1A08.2 Healthcare Requirements	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 3 of 4 individuals receiving Community Inclusion Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Annual Physical** (#1, 2) • **Dental Exam** ◦ Individual #1 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #2 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #3 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #1 – As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.	**Repeat Finding:** Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 4 individuals receiving Community Inclusion Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Annual Physical** (#2) • **Dental Exam** ◦ Individual #2 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ◦ Individual #3 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ◦ Individual #2 – As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Mammogram Exam**

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. **Chapter 6 (CCS) 3. Agency Requirements: G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements: 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.	◦ Individual #2 – As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. • **Mammogram Exam** ◦ Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 3/2015. Follow-up was to be completed in 12 months. No evidence of follow-up found.	◦ Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 3/2015. Follow-up was to be completed in 12 months. No evidence of follow-up found.

Chapter 13 (IMLS) 2. Service Requirements: C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)… Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes 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: (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP meeting and submitted to the Case Manager and all other IDT Members. A revised HAT is required to also be submitted whenever the		

individual's health status changes significantly. For individuals who are newly allocated to the DD Waiver program, the HAT may be completed within 2 weeks following the initial ISP meeting and submitted with any strategies and support plans indicated in the ISP, or within 72 hours following admission into direct services, whichever comes first. (2) Each individual will have a Health Care Coordinator, designated by the IDT. When the individual's HAT score is 4, 5 or 6 the Health Care Coordinator shall be an IDT member, other than the individual. The Health Care Coordinator shall oversee and monitor health care services for the individual in accordance with these standards. In circumstances where no IDT member voluntarily accepts designation as the health care coordinator, the community living provider shall assign a staff member to this role. (3) For each individual receiving Community Living Services, the provider agency shall ensure and document the following: (a) Provision of health care oversight consistent with these Standards as detailed in Chapter One section III E: Healthcare Documentation by Nurses For Community Living Services, Community Inclusion Services and Private Duty Nursing Services. b) That each individual with a score of 4, 5, or 6 on the HAT, has a Health Care Plan developed by a licensed nurse. (c) That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has Crisis Prevention/ Intervention Plan(s) developed by a licensed nurse or other appropriate professional for each such condition.		

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

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Condition of Participation Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. **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; **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. **Chapter 7 (CIHS) 3. Agency Requirements: E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements: D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 3 of 4 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • Electronic Comprehensive Health Assessment Tool (eCHAT) (#1, 2) • Medication Administration Assessment Tool (#1, 2) • Comprehensive Aspiration Risk Management Plan: ➢ Not Found (#1) • Aspiration Risk Screening Tool (#1, 2) • **Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:** ◦ None found for 10/2015 – 3/2016 (#1) ◦ None found for 4/2015 – 9/2015 (#1) ◦ None found for 9/2015 - 2/2016 (#2, 3) • **Special Health Care Needs:** • *Nutritional Evaluation* ◦ Individual #1 - According to IST section of the ISP, the individual is required to have an evaluation. No evidence of evaluation found.	**Repeat Finding:** Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 1 of 4 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • Medication Administration Assessment Tool (#1) • **Special Health Care Needs:** • *Nutritional Evaluation* ◦ Individual #1 - According to IST section of the ISP, the individual is required to have an evaluation. No evidence of evaluation found. • **Health Care Plans** • *Constipation* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.

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 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. 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. b. For individuals already in services, the required assessments are to be completed no more than forty-five (45) calendar days and at least fourteen (14) calendar days prior to the annual ISP meeting. c. Assessments must be updated within three (3) business days following any significant change of clinical condition and within three (3) business days following return from hospitalization. **d.** Other nursing assessments conducted to determine current health status or to evaluate a change in clinical condition must be documented in a signed progress note that includes time and date as well as subjective information including the individual complaints, signs and symptoms noted by	• **Health Care Plans** • *Allergies* ◦ Individual #2 – As indicated by the IST section of ISP, the individual is required to have a plan. No evidence of a plan found. • *Asthma* ◦ Individual #2 – As indicated by the IST section of the ISP, the individual is required to have a plan. No evidence of a plan found. • *Aspiration Risk* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Communication/Vision/Hearing* ◦ Individual #2 – As indicated by the IST section of the ISP, the individual is required to have a plan. No evidence of a plan found. • *Constipation* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Nutrition* ◦ Individual #2 – As indicated by the IST section of the ISP, the individual is required to have a plan. No evidence of a plan found. • *Psychoactive Medications* ◦ Individual #2 – As indicated by the IST section of the ISP, the individual is required to have a plan. No evidence of a plan found. • *Status of Hygiene Care* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the	

staff, family members or other team members; objective information including vital signs, physical examination, weight, and other pertinent data for the given situation (e.g., seizure frequency, method in which temperature taken); assessment of the clinical status, and plan of action addressing relevant aspects of all active health problems and follow up on any recommendations of medical consultants. **e.** Develop any urgently needed interim Healthcare Plans or MERPs per DDSD policy pending authorization of ongoing Adult Nursing services as indicated by health status and individual/guardian choice. **Chapter 12 (SL) 3. Agency Requirements: D. Consumer Records Policy:** All Living Supports- Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **2. Service Requirements. L. Training and Requirements. 5. Health Related Documentation:** For each individual receiving Living Supports- Supported Living, the provider agency must ensure and document the following: a. That an individual with chronic condition(s) with the potential to exacerbate into a life threatening condition, has a MERP developed by a licensed nurse or other appropriate professional according to the DDSD Medical Emergency Response Plan Policy, that DSP have been trained to implement such plan(s), and ensure that a copy of such plan(s) are readily available to DSP in the home;	individual is required to have a plan. No evidence of a plan found. • *Seizure Disorder* ◦ Individual #1 – 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** • *Aspiration* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Psychoactive Medications* ◦ Individual #2 – According to the IST section of the ISP, the individual is required to have a plan. No evidence of a plan found. • *Respiratory* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found. • *Respiratory/Asthma* ◦ Individual #2 – According to the IST section of the ISP, the individual is required to have a plan. No evidence of a plan found. • *Seizure Disorder* ◦ Individual #1 – According to Electronic Comprehensive Health Assessment Tool the individual is required to have a plan. No evidence of a plan found.	

b. That an average of five (5) hours of documented nutritional counseling is available annually, if recommended by the IDT and clinically indicated; c. That the nurse has completed legible and signed progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and d. Document for each individual that: i. The individual has a Primary Care Provider (PCP); ii. The individual receives an annual physical examination and other examinations as specified by a PCP; iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; iv. The individual receives a hearing test as specified by a licensed audiologist; v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). 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. **f.** The Supported Living Provider Agency must ensure that activities conducted by agency nurses comply with the roles and responsibilities identified in these standards. **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); G. Tri-annual vision exam (Not applicable for short term stays. See Medicaid policy 8.310.6 for allowable exceptions for more frequent vision exam); H. Audiology/hearing exam as applicable (Not applicable for short term stays; See Medicaid policy 8.324.6 for applicable requirements); I. All other evaluations called for in the ISP for which the Services provider is responsible to arrange; J. Medical screening, tests and lab results (for short term stays, only those which occur during the period of the stay); L. Record of medical and dental appointments, including any treatment provided (for short term stays, only those appointments that occur during the stay);		

O. Semi-annual ISP progress reports and MERP reviews (not applicable for short term stays); P. Quarterly nursing summary reports (not applicable for short term stays); **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **Department of Health Developmental Disabilities Supports Division Policy. Medical Emergency Response Plan Policy MERP-001 eff.8/1/2010** F. The MERP shall be written in clear, jargon free language and include at a minimum the following information: 1. A brief, simple description of the condition or illness. 2. A brief description of the most likely life threatening complications that might occur and what those complications may look like to an observer. 3. A concise list of the most important measures that may prevent the life threatening complication from occurring (e.g., avoiding allergens that trigger an asthma attack or making sure the person with diabetes has snacks with them to avoid hypoglycemia). 4. Clear, jargon free, step-by-step instructions		

regarding the actions to be taken by direct support personnel (DSP) and/or others to intervene in the emergency, including criteria for when to call 911. 5. Emergency contacts with phone numbers. 6. Reference to whether the individual has advance directives or not, and if so, where the advance directives are located. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case 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 activities (2) Health related plans and (4) General Nursing Documentation** Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 5 IV. COMMUNITY INCLUSION SERVICES PROVIDER AGENCY REQUIREMENTS B. IDT Coordination**		

(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.		

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
7.1.14.9 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All community-based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The community-based service provider shall ensure that the incident management system policies and procedures requires all employees and volunteers to be competently trained to respond to, report, and preserve evidence related to incidents in a timely and accurate manner. **E. Consumer and guardian orientation packet:** Consumers, family members, and legal guardians shall be made aware of and have available immediate access to the community-based service provider incident reporting processes. The community-based service provider shall provide consumers, family members, or legal guardians an orientation packet to include incident management systems policies and procedural information concerning the reporting of abuse, neglect, exploitation, suspicious injury, or death. The community-based service provider shall include a signed statement indicating the date, time, and place they received their orientation packet to be contained in the consumer's file. The appropriate consumer, family member, or legal guardian shall sign this at the time of orientation.	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 4 of 4 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#1, 2, 3, 4)	**Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 4 of 4 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Parent/Guardian Incident Management Training (Abuse, Neglect and Exploitation) (#1, 2, 3, 4)

Tag # 1A29 Complaints / Grievances Acknowledgement	Condition of Participation Level Deficiency	Condition of Participation Level Deficiency
NMAC 7.26.3.6 A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC]. **NMAC 7.26.3.13 Client Complaint Procedure Available.** A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01] **NMAC 7.26.4.13 Complaint Process:** **A. (2).** The service provider's complaint or grievance procedure shall provide, at a minimum, that: **(a)** the client is notified of the service provider's complaint or grievance procedure	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation, the complaint procedure had been made available to individuals or their legal guardians for 4 of 4 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Grievance/Complaint Procedure Acknowledgement (#1, 2, 3, 4) *Note: Agency did not have a Grievance / Complaint Procedure at the time of the on-site survey.*	**Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not provide documentation indicating consumer, family members, or legal guardians had received an orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 4 of 4 individuals. Review of the Agency individual case files revealed the following items were not found and/or incomplete: • Grievance/Complaint Procedure Acknowledgement (#1, 2, 3, 4)

Standard of Care	Routine Survey Deficiencies April 25 – 28, 2016	Verification Survey New and Repeat Deficiencies September 2 –7, 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**	**COMPLETE**
Tag # IS11 / 5I11 Reporting Requirements Inclusion 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 # 1A28.1 Incident Mgt. System - Personnel Training	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A43 General Events Reporting	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A03 CQI System	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A05 General Provider Requirements	**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 # 1A15 **Healthcare Documentation** **Nurse Contract/Employee**	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15.1 **Nurse Availability**	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A28 **Incident Mgt. System - Policy/Procedure**	**Condition of Participation 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 #1A12 All Services Reimbursement (No Deficiencies Found)		

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A22 Agency Personnel Competency	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**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 # 1A36 Service Coordination Requirements	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Tag #1A08.2 Healthcare Requirements	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A15.2 and IS09/5I09 Healthcare Documentation	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A29 Complaints/Grievances Acknowledgement	**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: January 3, 2017

To: Lisa Swanson, Executive Director

Provider: Southwest Services for the Deaf, Inc.
Address: 2202 Menual Boulevard NE #2
State/Zip: Albuquerque, New Mexico 87107

Mailing Address: 3301 R Coors Road NW
Suite 265
Albuquerque, New Mexico 87120

E-mail Address: lisaswsd@gmail.com

Region: Metro
Routine Survey: April 25 – 28, 2016
Verification Survey: September 2 – 7, 2016 & September 26 – 29, 2016

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Inclusion Supports* (Customized Community Supports)

Survey Type: Verification

Dear Ms. Swanson:

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

Your Plan of Correction will be considered for closure when a Verification survey confirms that you have corrected all survey deficiencies and sustained all corrections from the Verification survey which took place on September 2 – 7, 2016 & September 26 – 29, 2016.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Health Program Manager/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.1.DDW.D4238.5.VER.07.17.003

Date: May 5, 2017

To: Lisa Swanson, Executive Director

Provider: Southwest Services for the Deaf, Inc.
Address: 2202 Menaul Boulevard NE #2
State/Zip: Albuquerque, New Mexico 87107

E-mail Address: lisaswsd@gmail.com

Region: Metro
Routine Survey: April 25 – 28, 2016
Verification Survey: September 2 – 7, 2016 & September 26 – 29, 2016
Verification Survey 2: March 31 – April 4, 2017

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Inclusion Supports* (Customized Community Supports)

Survey Type: Verification

Team Leader: Barbara Kane, BAS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Team Members: Anthony Fragua, BFA, Health Program Manager, Division of Health Improvement/Quality Management Bureau and Chris Melon, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Swanson:

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 Verification *Survey on September 2 – 7, 2016 & September 26 – 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,

Barbara Kane, BAS

Barbara Kane, BAS
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	March 31, 2017	
Contact:	**Agency Name** Lisa Swanson, Executive Director / Service Coordinator **DOH/DHI/QMB** Barbara Kane, BAS, Team Lead/Healthcare Surveyor	
Entrance Conference Date:	April 3, 2017	
Present:	**Southwest Services for the Deaf, Inc.** Lisa Swanson, Executive Director / Service Coordinator Mary K Anderson, Interpreter Phillie Guillory, Interpreter **DOH/DHI/QMB** Barbara Kane, BAS, Team Lead/Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager Chris Melon, MPA, Healthcare Surveyor	
Exit Conference Date:	April 4, 2017	
Present:	**Southwest Services for the Deaf, Inc.** Lisa Swanson, Executive Director / Service Coordinator Tupper Dunbar, Trainer Advocate Mary K. Anderson, Interpreter **DOH/DHI/QMB** Barbara Kane, BAS, Team Lead/Healthcare Surveyor Anthony Fragua, BFA, Health Program Manager Chris Melon, MPA, Healthcare Surveyor **DDSD - Metro Regional Office** Jason Cornwell, Assistant Regional Director Terry-Ann Moore, Community Inclusion Coordinator	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	4 0 - *Jackson* Class Members 4 - Non-*Jackson* Class Members 4 - Customized Community Supports
Persons Served Records Reviewed	Number:	4
Direct Support Personnel Records Reviewed	Number:	4
Service Coordinator Records Reviewed	Number:	1 (*Executive Director also performs duties as Service Coordinator*)

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
    - 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
- 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 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: Plan of Care ISP Development & Monitoring

Condition of Participation:

5. **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:

6. **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:

7. **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:

8. **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:

6. **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:

5. 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.
6. 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
7. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
8. 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: **Southwest Services for the Deaf, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Inclusion Supports* (Customized Community Supports)
Monitoring Type: Verification Survey
Routine Survey: **April 25 – 28, 2016**
Verification Survey: **September 2 – 7, 2016 & September 26 – 29, 2016**
Verification Survey 2: **March 31 – April 4, 2017**

Standard of Care	Verification Survey New and Repeat Deficiencies September 2 – 7, 2016 & September 26 – 29, 2016	Verification Survey 2 New and Repeat Deficiencies March 31 – April 4, 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 # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Condition of Participation Level Deficiency**	**Standard Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities	**New/Repeat Finding:** After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 4 of 4 individuals. As indicated by Individuals' ISP, the following were found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**:	**Repeat Finding:** 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 outcomes and action plan for 1 of 4 individuals. As indicated by Individuals' ISP, the following were found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #2 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will attend and complete one quarter at CNM" for 2/2017

(CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities division (DDD), that to the extent permitted by funding, each individual receive supports and services that will assist and encourage independence and productivity in the community and attempt to prevent regression or loss of current capabilities. Services and supports include specialized and/or generic services, training, education and/or treatment as determined by the IDT and documented in the ISP. D. The intent is to provide choice and obtain opportunities for individuals to live, work and play with full participation in their communities. The following principles provide direction and purpose in planning for individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01]	Individual #1 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will actively participate in group discussion regarding scheduling activities for participation in" for 7/2016 – 8/2016. Action step is to be completed monthly. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will choose one activity for the group to participate in" for 7/2016 – 8/2016. Action step is to be completed monthly. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…will learn appropriate social greetings/basics on friendship building while in the community" for 7/2016 – 8/2016. Action step is to be completed weekly. Individual #2 • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will attend and complete one quarter at CNM" for 7/2016 – 8/2016. Action step is to be completed 1 – 2 times a week. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will complete homework" for 7/2016 – 8/2016. Action step is to be completed 1 – 2 times a week. Individual #3 • None found for 7/2016 – 8/2016. Individual #4	– 3/2017. Action step is to be completed 1 – 2 times a week. • None found regarding: Work/Education/Volunteer Outcome/Action Step: "…with staff support will complete homework" for 2/2017 – 3/2017. Action step is to be completed 1 – 2 times a week.

	• None found regarding: Live Outcome/Action Step: "…with staff prompts, will practice locking his home door" for 7/2016 – 8/2016. Action step is to be completed 2 times a week.	

Standard of Care	Verification Survey New and Repeat Deficiencies September 2 –7, 2016 & September 26 – 29, 2016	Verification Survey 2 New and Repeat Deficiencies March 31 – April 4, 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 #1A08.2 Healthcare Requirements	**Standard Level Deficiency**	**Standard Level Deficiency**
NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012 III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system.	**Repeat Finding:** Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 4 individuals receiving Community Inclusion Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Annual Physical** (#2) • **Dental Exam** ° Individual #2 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. ° Individual #3 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ° Individual #2 – As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found.	**Repeat Finding:** Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 1 of 4 individuals receiving Community Inclusion Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Dental Exam** Individual #3 – As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013 **Chapter 5 (CIES) 3. Agency Requirements** **H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy. **Chapter 6 (CCS) 3. Agency Requirements:** **G. Consumer Records Policy:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 7 (CIHS) 3. Agency Requirements:** **E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements:** **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	• **Mammogram Exam** ◦ Individual #3 - As indicated by collateral documentation reviewed, exam was completed on 3/2015. Follow-up was to be completed in 12 months. No evidence of follow-up found.	

required to comply with the DDSD Individual Case File Matrix policy. **Chapter 13 (IMLS) 2. Service Requirements:** C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items)… Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: D. Provider Agency Case File for the Individual:** All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes 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: (5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam; **CHAPTER 6. VI. GENERAL REQUIREMENTS FOR COMMUNITY LIVING** **G. Health Care Requirements for Community Living Services**. (1) The Community Living Service providers shall ensure completion of a HAT for each individual receiving this service. The HAT shall be completed 2 weeks prior to the annual ISP		

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

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

Standard of Care	Routine Survey Deficiencies April 25 – 28, 2016 and Verification Survey New and Repeat Deficiencies September 2 –7, 2016 & September 26 – 29, 2016	Verification Survey 2: New and Repeat Deficiencies March 31 – April 4, 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 # IS11 / 5I11 Reporting Requirements Inclusion 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 # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A11.1 Transportation Training	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A20 Direct Support Personnel Training	**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 # 1A36 Service Coordination Requirements	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A43 General Events Reporting	**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 # 1A05 General Provider Requirements	**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 # 1A15 Healthcare Documentation Nurse Contract/Employee	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15.1 Nurse Availability	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A28 Incident Mgt. System - Policy/Procedure	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A29 Complaints / Grievances Acknowledgement	**Condition of Participation 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 #1A12 All Services Reimbursement (No Deficiencies Found)		

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	

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

Date: June 16, 2017

To: Lisa Swanson, Executive Director

Provider: Southwest Services for the Deaf, Inc.
Address: 2202 Menaul Boulevard NE #2
State/Zip: Albuquerque, New Mexico 87107

E-mail Address: lisaswsd@gmail.com

Region: Metro
Routine Survey: April 25 – 28, 2016
Verification Survey: September 2 – 7, 2016 & September 26 – 29, 2016
Verification Survey 2: March 31 – April 4, 2017

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2012:*** *Inclusion Supports* (Customized Community Supports)

Survey Type: Verification

Dear Ms. Swanson:

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.17.3.DDW.D4238.5.VER.09.17.167