Date:	September 13, 2017
To:	Michelle Bishop-Couch, Chief Executive Officer
Provider:	Cornucopia Adult and Family Services, Inc.
Address:	2002 Bridge Blvd. SW
City/State/Zip:	Albuquerque, New Mexico 87105
E-Mail Address	michelle@cornucopia-ads.org
CC:	Michelle M. Mullen, President
Address:	1718 Central Avenue Southwest Suite D
City/State/Zip:	Albuquerque, New Mexico 87104
E-mail Address:	michele@mullenheller.com
Region:	Metro
Routine Survey:	November 11 – 17, 2016
Verification Survey:	August 7 – 11, 2017
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2012:*** *Living Supports* (Supported Living, Family Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports) ***2007:*** *Community Living* (Family Living) and *Community Inclusion* (Adult Habilitation, Community Access)
Survey Type:	Verification
Team Leader:	Amanda Castaneda, MPA, Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau
Team Members:	Chris Melon, MPA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Ms. Mullen;

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 November 11 – 17, 2016.*

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

Partial Compliance with Conditions of Participation

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

- Tag # 1A08.2 Healthcare Requirements
- Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation

- Tag # 1A28.2 Incident Mgt. System - Parent/Guardian Training

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,

Amanda Castaneda, MPA

Amanda Castaneda, MPA
Team Lead/ Plan of Correction Coordinator
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	August 7, 2017	
Contact:	**Cornucopia Adult and Family Services, Inc.** Michelle Bishop-Couch, Chief Executive Officer	
On-site Entrance Conference Date:	August 8, 2017	
Present:	**Cornucopia Adult and Family Services, Inc.** Michelle Bishop-Couch, Chief Executive Officer John Johnston, Program Director **DOH/DHI/QMB** Amanda Castaneda, MPA, Team Lead/Plan of Correction Coordinator Chris Melon, MPA, Healthcare Surveyor	
Exit Conference Date:	August 10, 2017	
Present:	**Cornucopia Adult and Family Services, Inc.** Michelle Bishop-Couch, Chief Executive Officer Melissa Velasquez, Registered Nurse Harold Tibbetts, Training Coordinator Judy Manicki, Human Resource Administrator Susan Bankroff, Service Coordinator Lorena Salinas, Data Clerk Veronica Dozal, Family Living/Supported Living Service Coordinator Sujana Chowdhury, Non-Waiver, Customized Community Supports-Individual Service Coordinator **DOH/DHI/QMB** Amanda Castaneda, MPA, Team Lead/ Plan of Correction Coordinator Chris Melon, MPA, Team Lead/Healthcare Surveyor	
Administrative Locations Visited	Number:	1
Total Sample Size	Number:	17 4 - *Jackson* Class Members 13 - Non-*Jackson* Class Members 3 - Supported Living 8 - Family Living 4 - Adult Habilitation 1 - Community Access 11 - Customized Community Supports 1 - Community Integrated Employment Services 3 - Customized In-Home Supports
Persons Served Records Reviewed	Number:	17
Direct Support Personnel Interviewed during Routine Survey	Number:	15
Direct Support Personnel Records Reviewed	Number:	59
Substitute Care/Respite Personnel		

Records Reviewed	Number:	12
Service Coordinator Records Reviewed	Number:	4

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
- Human Rights Committee Notes and Meeting Minutes
- Evacuation Drills of Residences and 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: **Cornucopia Adult and Family Services, Inc. – Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2012:*** *Living Supports* (Supported Living, Family Living); *Inclusion Supports* (Customized Community Supports, Community Integrated Employment Services) and *Other* (Customized In-Home Supports)
2007: *Community Living* (Family Living) and *Community Inclusion* (Adult Habilitation, Community Access)
Monitoring Type: Verification Survey
Routine Survey: **November 11 – 17, 2016**
Verification Survey: **August 7 – 11, 2017**

Standard of Care	Routine Survey Deficiencies November 11 – 17, 2016	Verification Survey New and Repeat Deficiencies August 7 – 11, 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**	**Standard Level Deficiency**
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 5 (CIES) 3. Agency Requirements** **J. Consumer Records Policy:** Community Integrated Employment 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 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. Additional documentation that is required to be maintained at the administrative office includes: 1. Vocational Assessments (if applicable) that are of quality and contain content acceptable to DVR and DDSD.	Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 9 of 18 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • **ISP budget forms MAD 046** ◦ Not Current (#16, 18) • **Current Emergency and Personal Identification Information** ◦ Did not contain Pharmacy phone number (#7) ◦ Did not contain Health Plan Information (#7) ◦ Did not contain Individual's phone number. (#14) • ISP Signature Page (#18) • **ISP Teaching and Support Strategies** ◦ *Individual #13 - TSS not found for the following*	**Repeat Findings:** Based on record review, the Agency did not maintain a complete and confidential case file at the administrative office for 3 of 17 individuals. Review of the Agency individual case files revealed the following items were not found, incomplete, and/or not current: • Behavior Crisis Intervention Plan (#11) • Speech Therapy Plan (#13) • Occupational Therapy Plan (#11, 13, 14)

Chapter 7 (CIHS) 3. Agency Requirements: **E. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 11 (FL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Family Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 12 (SL) 3. Agency Requirements:** **D. Consumer Records Policy:** All Living Supports-Supported Living Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Individual Case File Matrix policy. **Chapter 13 (IMLS) 2. Service Requirements:** C. Documents to be maintained in the agency administrative office, include: (This is not an all-inclusive list refer to standard as it includes other items) • Emergency contact information; • Personal identification; • ISP budget forms and budget prior authorization; • ISP with signature page and all applicable assessments, including teaching and support strategies, Positive Behavior Support Plan (PBSP), Behavior Crisis Intervention Plan (BCIP), or other relevant behavioral plans, Medical Emergency Response Plan (MERP), Healthcare Plan, Comprehensive Aspiration Risk Management Plan (CARMP), and Written Direct Support Instructions (WDSI); • Dated and signed evidence that the individual has been informed of agency grievance/complaint procedure at least annually, or upon admission for a	*Action Steps:* ◦ Live Outcome Statement: ➢ "…will open a savings account at the credit Union." ➢ "…will save money." ➢ "…will exercise for at least 20 minutes." ◦ *Individual #16 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement: ➢ "…will learn how to sweep the kitchen area and water the outside plants." • Positive Behavioral Support Plan (#12) • Behavior Crisis Intervention Plan (#11, 12) • Speech Therapy Plan (#2, 13) • Occupational Therapy Plan (#3, 11, 13, 14, 16) • Documentation of Guardianship/Power of Attorney (#2, 16)	

short term stay; • Copy of Guardianship or Power of Attorney documents as applicable; • Behavior Support Consultant, Occupational Therapist, Physical Therapist and Speech-Language Pathology progress reports as applicable, except for short term stays; • Written consent by relevant health decision maker and primary care practitioner for self-administration of medication or assistance with medication from DSP as applicable; • Progress notes written by DSP and nurses; • Signed secondary freedom of choice form; • Transition Plan as applicable for change of provider in past twelve (12) months. **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. **NMAC 8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:** A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. B. **Documentation of test results:** Results of tests and services must be documented, which includes results of laboratory and radiology procedures or progress following therapy or treatment.		

Tag # 1A32 and LS14 / 6L14 Individual Service Plan Implementation	Condition of Participation Level Deficiency	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 (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]	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 11 of 18 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #10 • None found regarding: Live Outcome/Action Step: "…will maintain her plants" for 8/2016 – 10/2016. Action step is to be completed 1 time per week. • None found regarding: Fun Outcome/Action Step: "…will be given 2 restaurant choices and choose a restaurant" for 8/2016 – 10/2016. Action step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Step: "…will go eat at chosen restaurant" for 8/2016 – 10/2016. Action step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Step: "…with assistance, will take a picture of	**New/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 2 of 17 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #13 • None found regarding: Live Outcome/Action Step: "With staff assistance, … will practice CPR steps" for 5/2017 – 6/2017. Action step is to be completed 2 times per month. • None found regarding: Live Outcome/Action Step: "… will explore different types of art and choose mediums he is interested in doing or learning" for 5/2017 – 6/2017. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "… will work on his art and choose his best pieces for his collection" for 5/2017 – 6/2017. Action step is to be completed 1 time per week. Individual #14 • None found regarding: Live Outcome/Action Step: "… will independently identify and purchase products needed for personal hygiene" for 5/2017

	her experience" for 8/2016. Action step is to be completed 1 time per month. • None found regarding: Fun Outcome/Action Step: "…will send picture to chosen family member" for 8/2016 – 10/2016. Action step is to be completed 1 time per month. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #1 • None found regarding: Live Outcome/Action Step: "…will select an item to purchase" for 10/2016. Action step is to be completed 2 times per month. • None found regarding: Live Outcome/Action Step: "…will exchange money with the cashier and get a receipt" for 10/2016. Action step is to be completed 2 times per month. • None found regarding: Fun Outcome/Action Step: "With assistance…will arrange an activity with a friend or family" for 10/2016. Action step is to be completed 1 time per month. Individual #2 • None found regarding: Live Outcome/Action Step: "...will receive assistance as needed to practice using dinner utensils" for 10/2016. Action step is to be completed 5 times per week. • According to the Live Outcome; Action Step for "…will receive assistance as needed to practice using dinner utensils" is to be completed 5 times per week, evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2016.	– 6/2017. Action step is to be completed 5 times per week. • None found regarding: Live Outcome/Action Step: "… will independently bathe, brush his hair, shave, and brush his teeth" for 5/2017 – 6/2017. Action step is to be completed 5 times per week. • None found regarding: Live Outcome/Action Step: "… will independently select clean clothes to wear appropriate to weather" for 5/2017 – 6/2017. Action step is to be completed 5 times per week.

	Individual #7 • None found regarding: Live Outcome/Action Step: "…will choose what she inputs" for 8/2016 – 10/2016. Action step is to be completed 1 time per week. • None found regarding: Live Outcome/Action Step: "…will assist in inputting info into her app" for 8/2016 – 10/2016. Action step is to be completed 1 time per week. Individual #16 • None found regarding: Live Outcome/Action Step: "…will learn how to sweep the kitchen area and water the outside plants" for 8/2016 – 10/2016. Action step is to be completed 1 time per week. Individual #17 • According to the Live Outcome; Action Step for "…will engage in his exercise routine" is to be completed daily. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016 - 10/2016. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #4 • According to the Work/Learn Outcome; Action Step for "…will choose the language activity he wants to do from his activity folder" is to be completed 3 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016 and 10/2016. • According to the Work/Learn Outcome; Action Step for "…will engage in his chosen language activity up to 5 minutes" is to be completed 3	

	times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016 and 10/2016. Individual #7 • None found regarding: Work/learn Outcome/Action Step: "…will complete duties on her list provided by Koslet" for 9/2016. Action step is to be completed 1 time per week. • None found regarding: Health Outcome/Action Step: "…will work out at gym" for 9/2016 – 10/2016. Action step is to be completed 2 times per week. Individual #14 • None found regarding: Fun Outcome/Action Step: "With staff assistance…will select activity" for 9/2016 – 10/2016. Action step is to be completed 2 times per week. • None found regarding: Fun Outcome/Action Step: "…will participate in chosen activity" for 9/2016 – 10/2016. Action step is to be completed 2 times per week. **Adult Habilitation Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #8 • According to the Work/Learn Outcome; Action Step for "Fill can until told to stop" is to be completed 4 times per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016 – 10/2016. • According to the Work/Learn Outcome; Action Step for "Participate in Grower's Market" is to be completed 4 times per month. Evidence found	

	indicated it was not being completed at the required frequency as indicated in the ISP for 10/2016. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #13 • According to the Live Outcome; Action Step for "…will save money" is to be completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016 – 10/2016. Individual #14 • According to the Live Outcome; Action Step for "…will independently identify and purchase products for personal hygiene" is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016. • None found regarding: Live Outcome/Action Step: "…will independently identify and purchase products for personal hygiene" for 9/2016 - 10/2016. Action step is to be completed 5 times per week. • According to the Live Outcome; Action Step for "…will independently bathe, brush his hair, shave, and brush his teeth" is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016. • None found regarding: Live Outcome/Action Step: "…will independently bathe, brush his hair, shave, and brush his teeth" for 9/2016 - 10/2016. Action step is to be completed 5 times per week.	

	• According to the Live Outcome; Action Step for "…will independently select clean clothes to wear appropriate to the weather" is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 8/2016. **Residential Files Reviewed:** **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #9 • According to the Live Outcome; Action Step for "Water, fertilize, and weed" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. • According to the Fun Outcome; Action Step for "Look through magazines with staff" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1– 11, 2016. • According to the Fun Outcome; Action Step for "Reminisce in her sanctuary" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. Individual #10 • According to the Live Outcome; Action Step for "…will maintain herb plants" is to be completed 1 time per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11,	

	2016. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #2 • According to the Live Outcome; Action Step for "…will receive assistance as needed to practice using dinner utensils" is to be completed 5 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. • According to the Live Outcome; Action Step for "…will eat his meals" is to be completed 7 times per week. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. Individual #8 • According to the Live Outcome; Action Step for "Plate and cup will be put in same place each time for … to access" is to be completed 2 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. • According to the Live Outcome; Action Step for "…will pick up her plate and place it on the placement in the correct spot" is to be completed 2 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. • According to the Live Outcome; Action Step for "…will pick up the cup" is to be completed 2 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016.	

	• According to the Live Outcome; Action Step for "Once … picks up the cup, FLP will assist her with putting it on the placement in the correct spot" is to be completed 2 times per week evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 11/1 – 11, 2016. Individual #16 • None found regarding: Live Outcome/Action Step: "…will learn how to sweep the kitchen area and water the outside plants" for 11/1 – 11, 2016. Action step is to be completed 1 time per week.	

Tag # LS14 / 6L14 Residential Case File	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 12 (SL) 3. Agency Requirements** **C. Residence Case File:** The Agency must maintain in the individual's home a complete and current confidential case file for each individual. Residence case files are required to comply with the DDSD Individual Case File Matrix policy. **CHAPTER 13 (IMLS) 2. Service Requirements** **B.1. Documents to Be Maintained in The Home:** a. Current Health Passport generated through the e-CHAT section of the Therap website and printed for use in the home in case of disruption in internet access; b. Personal identification; c. Current ISP with all applicable assessments, teaching and support strategies, and as applicable for the consumer, PBSP, BCIP, MERP, health care plans, CARMPs, Written Therapy Support Plans, and any other plans (e.g. PRN Psychotropic Medication Plans) as applicable; d. Dated and signed consent to release information forms as applicable; e. Current orders from health care practitioners; f. Documentation and maintenance of accurate medical history in Therap website; g. Medication Administration Records for the current month; h. Record of medical and dental appointments for	Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 12 of 12 Individuals receiving Family Living Services and Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • **Current Emergency and Personal Identification Information** ◦ None Found (#1, 6, 10, 16) ◦ Did not contain Individual's phone number. (#2, 8, 15, 18) ◦ Did not contain Health Plan Information (#2, 7, 15) ◦ Did not contain Pharmacy Information (#15, 18) • **ISP Teaching and Support Strategies** ◦ *Individual #2 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "…will receive assistance as needed to practice using dinner utensils." ➢ "…will eat his meals." ◦ *Individual #3 - TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "…will participate in range of motion exercises." ➢ "…will practice her drinking skills." ◦ Individual #7 - *TSS not found for the following*	**Repeat Finding:** Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 2 of 9 Individuals receiving Family Living Services and Supported Living Services. Review of the residential individual case files revealed the following items were not found, incomplete, and/or not current: • Occupational Therapy Plan (#17) • Physical Therapy Plan (#1)

the current year, or during the period of stay for short term stays, including any treatment provided; i. Progress notes written by DSP and nurses; j. Documentation and data collection related to ISP implementation; k. Medicaid card; l. Salud membership card or Medicare card as applicable; and m. A Do Not Resuscitate (DNR) document and/or Advanced Directives as applicable. **DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION (DDSD): Director's Release: Consumer Record Requirements eff. 11/1/2012** **III. Requirement Amendments(s) or Clarifications:** A. All case management, living supports, customized in-home supports, community integrated employment and customized community supports providers must maintain records for individuals served through DD Waiver in accordance with the Individual Case File Matrix incorporated in this director's release. H. Readily accessible electronic records are accessible, including those stored through the Therap web-based system. ***Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007*** **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** **A. Residence Case File:** For individuals receiving Supported Living or Family Living, the Agency shall maintain in the individual's home a complete and current confidential case file for each individual. For individuals receiving Independent Living Services, rather than maintaining this file at the individual's home, the complete and current confidential case file for each individual shall be	*Action Steps:* ◦ Live Outcome Statement ➢ "…will choose what she inputs." ➢ "…will assist … in inputting info into her app." ◦ Individual #15 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "…will plant tomato seeds." ◦ Individual #16 - *TSS not found for the following Action Steps:* ◦ Live Outcome Statement ➢ "…will learn how to sweep the kitchen area and water the outside plants." ◦ Individual #16 - *TSS not found for the following Action Steps:* ◦ Fun Outcome Statement ➢ "…will successfully try new community activities." • Positive Behavioral Plan (#3, 17) • Behavior Crisis Intervention Plan (#18) • Speech Therapy Plan (#2, 3, 8, 10, 17) • Occupational Therapy Plan (#7, 8, 16, 17) • Physical Therapy Plan (#1, 8, 17) • Healthcare Passport (#8, 16, 17) • **Special Health Care Needs** ◦ Nutritional Plan (#6) ◦ Comprehensive Aspiration Risk Management Plan: ➢ Not Current (#8, 10, 16, 17)	

maintained at the agency's administrative site. Each file shall include the following: (1) Complete and current ISP and all supplemental plans specific to the individual; (2) Complete and current Health Assessment Tool; (3) Current emergency contact information, which includes the individual's address, telephone number, names and telephone numbers of residential Community Living Support providers, relatives, or guardian or conservator, primary care physician's name(s) and telephone number(s), pharmacy name, address and telephone number and dentist name, address and telephone number, and health plan; (4) Up-to-date progress notes, signed and dated by the person making the note for at least the past month (older notes may be transferred to the agency office); (5) Data collected to document ISP Action Plan implementation (6) Progress notes written by direct care staff and by nurses regarding individual health status and physical conditions including action taken in response to identified changes in condition for at least the past month; (7) Physician's or qualified health care providers written orders; (8) Progress notes documenting implementation of a physician's or qualified health care provider's order(s); (9) Medication Administration Record (MAR) for the past three (3) months which includes: (a) The name of the individual; (b) A transcription of the healthcare practitioner's prescription including the brand and generic name of the medication; (c) Diagnosis for which the medication is prescribed; (d) Dosage, frequency and method/route of	• **Health Care Plans** ◦ Aspiration (#17) ◦ Bowel/Bladder (#3) ◦ Constipation (#3, 17) ◦ Falls (#3) ◦ Hydration (#3) ◦ Incontinence (#17) ◦ Seizures (#17) ◦ Skin and Wound (#3, 17) • **Medical Emergency Response Plans** ◦ Aspiration (#2, 3, 17) ◦ Falls (#3) ◦ Methicillin-Resistant Staphylococcus Aureus (MRSA) (#17) ◦ Respiratory (#1) ◦ Seizures (#2, 17) • **Progress Notes/Daily Contacts Logs:** ◦ Individual #7 - None found for 11/1 – 13, 2016 ◦ Individual #9 - None found for 11/2/2016 ◦ Individual #10 - None found for 11/3/2016. ◦ Individual #16 - None found for 11/1 –14, 2016.	

delivery; (e) Times and dates of delivery; (f) Initials of person administering or assisting with medication; and (g) An explanation of any medication irregularity, allergic reaction or adverse effect. (h) For PRN medication an explanation for the use of the PRN must include: (i) Observable signs/symptoms or circumstances in which the medication is to be used, and (ii) Documentation of the effectiveness/result of the PRN delivered. (i) A MAR is not required for individuals participating in Independent Living Services who self-administer their own medication. However, when medication administration is provided as part of the Independent Living Service a MAR must be maintained at the individual's home and an updated copy must be placed in the agency file on a weekly basis. (10) Record of visits to healthcare practitioners including any treatment provided at the visit and a record of all diagnostic testing for the current ISP year; and (11) Medical History to include: demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability and any psychiatric diagnosis, allergies (food, environmental, medications), status of routine adult health care screenings, immunizations, hospital discharge summaries for past twelve (12) months, past medical history including hospitalizations, surgeries, injuries, family history and current physical exam.		

Tag # LS17 / 6L17 Reporting Requirements (Community Living Reports)	Standard Level Deficiency	Standard Level Deficiency
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 3. Agency Requirements: E. Living Supports- Family Living Service Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Family Living Provider must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation: a. Name of individual and date on each page;	Based on record review, the Agency did not complete written status reports for 3 of 12 individuals receiving Living Services. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Family Living Semi- Annual Reports:** • Individual #6 - None found for May 2015 - November 2015. *(Term of ISP 5/30/2015 - 5/29/2016).* • Individual #16 - None found for July 2015 – December 2015 and January 2016 - April 2016. *(Term of ISP 7/29/2015 – 7/28/2016) (ISP meeting held 5/3/2016).* • Individual #18 - None found for April 2015 – October 2015 and November 2015 - January 2016. *(Term of ISP 4/26/15 – 4/25/2016) (ISP meeting held 1/21/2016).*	**Repeat Finding:** Based on record review, the Agency did not complete written status reports for 1 of 11 individuals receiving Living Services. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Family Living Semi- Annual Reports:** • Individual #18 - None found for April 2015 – October 2015 and November 2015 - January 2016. *(Term of ISP 4/26/15 – 4/25/2016) (ISP meeting held 1/21/2016).*

b. Timely completion of relevant activities from ISP Action Plans; c. Progress towards desired outcomes in the ISP accomplished during the past six months; d. Significant changes in routine or staffing; e. Unusual or significant life events, including significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports. **CHAPTER 12 (SL) 3. Agency Requirements: E. Living Supports- Supported Living Service Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Supported Living providers must submit written semi-annual status reports to the individual's Case Manager and other IDT Members no later than one hundred ninety (190) calendar days after the ISP effective date. When reports are developed in any other language than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation: a. Name of individual and date on each page; b. Timely completion of relevant activities from ISP Action Plans; c. Progress towards desired outcomes in the ISP accomplished during the past six (6) months; d. Significant changes in routine or staffing; e. Unusual or significant life events, including		

significant change of health condition; f. Data reports as determined by IDT members; and g. Signature of the agency staff responsible for preparing the reports. **CHAPTER 13 (IMLS) 3. Agency Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program:** 4. Intensive Medical Living Services providers shall submit a written semi-annual (non-nursing) status report to the individual's case manager and other IDT members no later than the one hundred ninetieth (190th) day following ISP effective date. These semi-annual status reports shall contain at least the following information: a. Status of completion of ISP Action Plans and associated support plans and/or WDSI; b. Progress towards desired outcomes; c. Significant changes in routine or staffing; d. Unusual or significant life events; and e. Data reports as determined by the IDT members; Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. VIII. COMMUNITY LIVING SERVICE PROVIDER AGENCY REQUIREMENTS** D. Community Living Service Provider Agency Reporting Requirements: **All Community Living Support providers shall submit written quarterly status reports to the individual's Case Manager and other IDT Members no later than fourteen (14) days following the end of each ISP quarter. The quarterly reports shall contain the following**		

written documentation: (1) Timely completion of relevant activities from ISP Action Plans (2) Progress towards desired outcomes in the ISP accomplished during the quarter; (3) Significant changes in routine or staffing; (4) Unusual or significant life events; (5) Updates on health status, including medication and durable medical equipment needs identified during the quarter; and (6) Data reports as determined by IDT members.		

Tag # IH17 Reporting Requirements (Customized In-Home Supports Reports)	Standard Level Deficiency	Standard Level Deficiency
7.26.5.17 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - DISSEMINATION OF THE ISP, DOCUMENTATION AND COMPLIANCE: C. Objective quantifiable data reporting progress or lack of progress towards stated outcomes, and action plans shall be maintained in the individual's records at each provider agency implementing the ISP. Provider agencies shall use this data to evaluate the effectiveness of services provided. Provider agencies shall submit to the case manager data reports and individual progress summaries quarterly, or more frequently, as decided by the IDT. These reports shall be included in the individual's case management record, and used by the team to determine the ongoing effectiveness of the supports and services being provided. Determination of effectiveness shall result in timely modification of supports and services as needed. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 7 (CIHS) 3. Agency Requirements: F. Customized In-Home Supports Provider Agency Reporting Requirements:** 1. **Semi-Annual Reports:** Customized In-Home Supports providers must submit written semi-annual status reports to the individual's Case Manager and other IDT members no later than one hundred ninety (190) calendar days after the ISP effective date and fourteen (14) calendar days prior to the annual ISP meeting. When reports are developed in any language other than English, it is the responsibility of the provider to translate the reports into English. The semi-annual reports must contain the following written documentation:	Based on record review, the Agency did not complete written status reports for 1 of 3 individuals receiving Customized In-Home Supports. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Customized In-Home Supports Semi-Annual Reports:** • Individual #13 - None found for September 2015 – October 2015 *(Term of ISP 2/28/2015 – 2/27/2016) (ISP Meeting held 11/2/2015).*	**Repeat Finding:** Based on record review, the Agency did not complete written status reports for 1 of 3 individuals receiving Customized In-Home Supports. Review of the Agency individual case files revealed the following items were not found, and/or incomplete: **Customized In-Home Supports Semi-Annual Reports:** • Individual #13 - None found for September 2015 – October 2015 *(Term of ISP 2/28/2015 – 2/27/2016) (ISP Meeting held 11/2/2015).*

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

Standard of Care	Routine Survey Deficiencies November 11 – 17, 2016	Verification Survey New and Repeat Deficiencies August 7 – 11, 2017
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implement its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A20 **Direct Support Personnel Training**	**Standard Level Deficiency**	**Standard Level Deficiency**
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - **II. POLICY STATEMENTS:** A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual-specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) of each individual served. C. Staff shall complete training on DOH-approved incident reporting procedures in accordance with 7 NMAC 1.13. D. Staff providing direct services shall complete training in universal precautions on an annual basis. The training materials shall meet Occupational Safety and Health Administration (OSHA) requirements. E. Staff providing direct services shall maintain certification in first aid and CPR. The training materials shall meet OSHA requirements/guidelines. F. Staff who may be exposed to hazardous chemicals shall complete relevant training in accordance with OSHA requirements. G. Staff shall be certified in a DDSD-approved behavioral intervention system (e.g., Mandt, CPI) before using physical restraint techniques. Staff members providing direct services shall maintain certification in a DDSD-approved behavioral intervention system if an individual they support has a behavioral crisis plan that includes the use of physical restraint techniques. H. Staff shall complete and maintain certification in a DDSD-approved medication course in accordance with the DDSD Medication Delivery Policy M-001. I. Staff providing direct services shall complete safety training within the first thirty (30) days of employment	Based on record review, the Agency did not ensure Orientation and Training requirements were met 25 of 66 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • Pre- Service (DSP #200, 205, 211, 215, 223, 231, 237, 244, 249, 251, 258) • Foundation for Health and Wellness (DSP #200, 205, 211, 215, 223, 237, 243, 244, 249, 258, 261) • Person-Centered Planning (1-Day) (DSP #200, 215, 223, 237, 254, 258) • Assisting with Medication Delivery (DSP #216, 223, 224, 226, 227, 229, 246, 258, 263) • First Aid (DSP #200, 216, 221, 243, 254, 258) • CPR (DSP #200, 221, 243, 254, 258) • Participatory Communication and Choice Making (DSP #215, 243, 253, 257, 258) • Advocacy 101 (DSP #215, 243, 258) • Supporting People with Challenging Behaviors (DSP #215, 243, 253, 257, 258)	**Repeat Finding:** Based on record review, the Agency did not ensure Orientation and Training requirements were met 1 of 59 Direct Support Personnel. Review of Direct Support Personnel training records found no evidence of the following required DOH/DDSD trainings and certification being completed: • First Aid (DSP #254) • CPR (DSP #254)

and before working alone with an individual receiving service. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **CHAPTER 7 (CIHS) 3. Agency Requirements C. Training Requirements:** The Provider Agency must report required personnel training status to the DDSD Statewide Training Database as specified in the DDSD Policy T-001: Reporting and Documentation of DDSD Training Requirements Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider	• Teaching and Support Strategies (DSP #215, 243, 253, 257, 258)	

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

Tag # 1A22 Agency Personnel Competency	Condition of Participation Level Deficiency	Standard Level Deficiency
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **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	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 8 of 20 Direct Support Personnel. **When DSP were asked what Outcomes they are responsible for, the following was reported:** • DSP #236 stated, "I don't know. I don't work with Outcomes." DSP #236 provides Supported Living services and is responsible Implementing Actions Steps under the Live and Fun Outcomes. (Individual #9) **When DSP were asked if the individual had a Behavioral Crisis Intervention Plan and if so, what the plan covered, the following was reported:** • DSP #202 stated, "I know she does. Don't remember for sure now (what it covers)." According to the Individual Specific Training Section of the ISP, the individual has Behavioral Crisis Intervention Plan. (Individual #16) **When DSP were asked if the Individual had a Speech Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #202 stated, "Not sure what it covers." According to the Individual Specific Training Section of the ISP, the Individual requires a Speech Therapy Plan. (Individual #16) **When DSP were asked if the Individual had an Occupational Therapy Plan and if so, what the**	**Repeat Finding:** Based on record review, the Agency did not fully implement the Plan of Correction for Agency Personnel Competency. As stated in the Plan of Correction approved on 4/14/2017, "…every Service Coordinator does a peer to peer training on IST annually which aligns with the new ISP." Based on record review, the Agency did not ensure training competencies were met for 2 of 15 Direct Support Personnel. **Documentation of re-training was not found for the following:** • DSP #235 o Health Care Plan – Aspiration, Falls and Respiration. (Individual #12) • DSP#254 o Health Care Plan - Status of Care/Hygiene, Falls, Pain, Skin and Wound, Alcohol Use and Level of Participation. (Individual #13) o Medical Emergency Response Plan – Falls Risk Medications. (Individual #13)

Policy. The Provider Agency must ensure that the personnel support staff have completed training as specified in the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Staff shall complete individual specific training requirements in accordance with the specifications described in the ISP of each individual served; and 4. Staff that assists the individual with medication (e.g., setting up medication, or reminders) must have completed Assisting with Medication Delivery (AWMD) Training. **CHAPTER 11 (FL) 3. Agency Requirements B. Living Supports- Family Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Family Living Provider agencies must ensure staff training in accordance with the Training Requirements for Direct Service Agency Staff policy. DSP's or subcontractors delivering substitute care under Family Living must at a minimum comply with the section of the training policy that relates to Respite, Substitute Care, and personal support staff [Policy T-003: for Training Requirements for Direct Service Agency Staff; Sec. II-J, Items 1-4]. Pursuant to the Centers for Medicare and Medicaid Services (CMS) requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Family Living Provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. 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	**plan covered, the following was reported:** • DSP #202 stated, "I am at a loss, not sure." According to the Individual Specific Training Section of the ISP, the Individual requires an Occupational Therapy Plan. (Individual #16) **When DSP were asked if the Individual had a Physical Therapy Plan and if so, what the plan covered, the following was reported:** • DSP #202 stated, "Yes." According to the Individual Specific Training Section of the ISP the Individual does <u>not</u> require a Physical Therapy Plan. (Individual #16) **When DSP were asked if the Individual had Health Care Plans and if so, what the plan(s) covered, the following was reported:** • DSP #202 stated, "Constipation." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Body Mass Index, Aspiration and Respiratory. (Individual #16) • DSP #210 stated, "Aspiration and Constipation." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Bowel and Bladder, Falls and Skin and Wound. (Individual #3) • DSP #211 stated, "Respiratory." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Body Mass Index. (Individual #1) • DSP #235 stated, "Constipation and Seizures." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires Health Care Plans for Aspiration, Falls	

regard to privacy, communication style, and routines. Individual specific training for therapy related WDSI, Healthcare Plans, MERPs, CARMP, PBSP, and BCIP must occur at least annually and more often if plans change or if monitoring finds incorrect implementation. Family Living providers must notify the relevant support plan author whenever a new DSP is assigned to work with an individual, and therefore needs to receive training, or when an existing DSP requires a refresher. The individual should be present for and involved in individual specific training whenever possible. **CHAPTER 12 (SL) 3. Agency Requirements B. Living Supports- Supported Living Services Provider Agency Staffing Requirements: 3. Training:** A. All Living Supports- Supported Living Provider Agencies must ensure staff training in accordance with the DDSD Policy T-003: for Training Requirements for Direct Service Agency Staff. Pursuant to CMS requirements, the services that a provider renders may only be claimed for federal match if the provider has completed all necessary training required by the state. All Supported Living provider agencies must report required personnel training status to the DDSD Statewide Training Database as specified in DDSD Policy T-001: Reporting and Documentation for DDSD Training Requirements. B Individual specific training must be arranged and conducted, including training on the ISP Outcomes, actions steps and strategies, associated support plans (e.g. health care plans, MERP, PBSP and BCIP, etc), and information about the individual's preferences with regard to privacy, communication 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	and Respiration. (Individual #12) • DSP #236 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Health Care Plan for Constipation. (Individual #9) • DSP #254 stated, "I haven't heard from her (nurse), so no." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Health Care Plans for Status of Care/Hygiene, Falls, Pain, Skin and Wound, Alcohol Use and Level of Participation. (Individual #13) **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 #202 stated, "Not sure." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires Medical Emergency Response Plans for Aspiration and Respiratory. (Individual #16) • DSP #210 stated, "Aspiration." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual also requires a Medical Emergency Response Plan for Falls. (Individual #3) • DSP #211 stated, "Call 911." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual requires a Medical Emergency Response Plan for Respiratory. (Individual #1) • DSP #254 stated, "I haven't heard from her (nurse), so no." As indicated by the Electronic Comprehensive Health Assessment Tool, the	

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;	Individual requires a Medical Emergency Response Plan for Falls. (Individual #13) **When DSP were asked if the Individual had Bowel and Bladder issues, the following was reported:** • DSP #236 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the Individual has bowel issues and requires a Health Care Plan for Constipation. (Individual #9) **When DSP were asked, what are the steps did they need to take before assisting an individual with PRN medication, the following was reported:** • DSP #204 stated, "Call the nurse, leave message and tell her what Individual was given, nurse will call back." According to DDSD Policy Number M-001 prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. (Individual #16) **When DSP were asked what the individual's Diagnosis were, the following was reported:** • DSP #210 stated, "Down's Syndrome, Dementia, Hypothyroidism, and Non-Verbal." According to the Individual's ISP she is also diagnosed with Frontal Lobe Syndrome, Alzheimer's, Arthritis, Osteopenia and Hearing Deficit. Staff did not discuss the listed diagnosis. (Individual #3) **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 #202 stated, "I think she just has seasonal allergies." As indicated by the Electronic Comprehensive Health Assessment Tool individual is allergic to Sulfonamides. (Individual #16) • DSP #236 stated, "No." As indicated by the Electronic Comprehensive Health Assessment Tool, the individual is allergic to Haldol. (Individual #9)	

Tag # 1A37 Individual Specific Training	Standard Level Deficiency	Standard Level Deficiency
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy - Policy Title: Training Requirements for Direct Service Agency Staff Policy - Eff. March 1, 2007 - II. POLICY STATEMENTS: A. Individuals shall receive services from competent and qualified staff. B. Staff shall complete individual specific (formerly known as "Addendum B") training requirements in accordance with the specifications described in the individual service plan (ISP) for each individual serviced. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 3. Agency Requirements G. Training Requirements: 1.** All Community Inclusion Providers must provide staff training in accordance with the DDSD policy T-003: Training Requirements for Direct Service Agency Staff Policy. 3. Ensure direct service personnel receives Individual Specific Training as outlined in each individual ISP, including aspects of support plans (healthcare and behavioral) or WDSI that pertain to the employment environment. **CHAPTER 6 (CCS) 3. Agency Requirements F. Meet all training requirements as follows: 1.** All Customized Community Supports Providers shall provide staff training in accordance with the DDSD Policy T-003: Training Requirements for Direct Service Agency Staff Policy; **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	Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 15 of 70 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (DSP #200, 205, 208, 211, 215, 223, 231, 236, 237, 244, 247, 249, 257, 258, 263)	**Repeat Finding:** Based on record review, the Agency did not ensure that Individual Specific Training requirements were met for 3 of 63 Agency Personnel. Review of personnel records found no evidence of the following: **Direct Support Personnel (DSP):** • Individual Specific Training (DSP #211, 215, 263)

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

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

Tag # 1A43 General Events Reporting	Standard Level Deficiency	Standard Level Deficiency
Department of Health (DOH) Developmental Disabilities Supports Division (DDSD) Policy: General Events Reporting Effective 1/1/2012 **1. Purpose** To report, track and analyze significant events experiences by adult participants of the DD Waiver program, which do not meet criteria for abuse, neglect or exploitation, or other "reportable incident" as defined by the Incident Management Bureau of the Division of Health Improvement, Department of Health, but which pose a risk to individuals served. Analysis of reported significant events is intended to identify emerging patterns so that preventative actions can be identified at the individual, provider agency, regional and statewide levels. **II. Policy Statements** A. Designated employees of each agency will enter specified information into the General Events Reporting section of the secure website operated under contract by Therap Services within 2 business days of the occurrence or knowledge by the reporting agency of any of the following defined events in which DDSD requires reporting: Chocking, Missing Person, Suicide Attempt or Threat, Restraint related to Behavior, Serious Injury including Skin Breakdown, Fall (with or without injury), Out of Home Placement and Infections…Providers shall utilize the "Significant Events Reporting System Guide" to assure that events are reported correctly for DDSD tracking purposes. At providers' discretion additional events may be tracked within the Therap General Events Reporting which are not required by DDSD such as medication errors. B. General Events Reporting does not replace	Based on record review the Agency did not follow the General Events Reporting requirements as indicated by the policy for 1 of 18 individuals. **The following General Events Reporting records contained evidence that indicated the General Events Report was not entered and approved within 2 business days:** Individual #8 General Events Report (GER) indicates on 10/7/2016 the Individual was taken to Urgent Care. (Hospital) GER was approved 11/17/2016.	**New Finding:** Based on the Agency's Plan of Correction approved on 4/14/2017, "…the Program Director was trained on Therap on 3/31/2017 by Kathy Baker / Hernado Martinez." No evidence of completed Therap training was provided during the on-site Verification Survey completed on August 7 – 11, 2017.

agency obligations to report abuse, neglect, exploitation and other reportable incidents in compliance with policies and procedures issued by the Department's Incident Management Bureau of the Division of Health Improvement.		

Standard of Care	Routine Survey Deficiencies November 11 – 17, 2016	Verification Survey New and Repeat Deficiencies August 7 – 11, 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 # 1A03 CQI System	**Standard Level Deficiency**	**Standard Level Deficiency**
STATE OF NEW MEXICO DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION PROVIDER AGREEMENT: ARTICLE 17. PROGRAM EVALUATIONS d. PROVIDER shall have a Quality Management and Improvement Plan in accordance with the current MF Waiver Standards and/or the DD Waiver Standards specified by the DEPARTMENT. The Quality Management and Improvement Plan for DD Waiver Providers must describe how the PROVIDER will determine that each waiver assurance and requirement is met**.** The applicable assurances and requirements are: (1) level of care determination; (2) service plan; (3) qualified providers; (4) health and welfare; (5) administrative authority; and, (6) financial accountability. For each waiver assurance, this description must include: i. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance; ii. The entities or individuals responsible for conducting the discovery/monitoring processes; iii. The types of information used to measure performance; and, iv. The frequency with which performance is measured.	Based on record review, the Agency had not fully implemented their Continuous Quality Management System as required by standard. • Review of the findings identified during the on-site survey (November 11 – 17, 2016) and as reflected in this report of findings, the Agency had multiple deficiencies noted, including Conditions of Participation out of compliance, which indicates the CQI plan provided by the Agency was not being used to successfully identify and improve systems within the agency. • In addition, the Agency's CQI Plan did not contain the following components: a. Analysis of General Events Reports data in Therap; b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns/Trends of reportable incidents; f. Results of improvement actions taken in previous quarters; g. Sufficiency of staff coverage; h. Action taken regarding individual grievances;	**Repeat Finding:** Based on record review, the Agency did not develop and implement a Continuous Quality Management System. Review of the findings from the **November 11 – 17, 2016** survey indicated the Agency had multiple deficiencies noted. Nevertheless, during the verification survey the agency continues to have substantial deficiencies, which either were not corrected nor addressed since the last survey. When requested, a copy of the current Continuous Quality Management system was not provided during the on-site Verification Survey completed on August 7 – 11, 2017 to verify the following components had been included in the CQI system. a. Analysis of General Events Reports data in Therap; b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns/Trends of reportable incidents; f. Results of improvement actions taken in previous quarters; g. Sufficiency of staff coverage;

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 1 Introduction:** As outlined in the quality assurance/quality improvement section in each of the service standards, all approved DDW providers are required to develop and utilize a quality assurance/quality improvement (QA/QI) plan to continually determine whether it operates in accordance with program requirements and regulations, achieves desired outcomes and identifies opportunities for improvement. CMS expects states to follow a continuous quality improvement process to monitor the implementation of the waiver assurances and methods to address identified problems in any area of non-compliance. **CHAPTER 5 (CIES) 3. Agency Requirements: Quality Assurance Quality Improvement (QA/QI) Plan**: Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. 1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall	i. Results of General Events Reporting data analysis, Trends in category II significant events; j. Significant program changes. k. Patterns / Trends in medication errors	h. Action taken regarding individual grievances; i. Results of General Events Reporting data analysis, Trends in category II significant events; j. Significant program changes. k. Patterns / Trends in medication errors

include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance. b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. Implementation of the ISP, including: i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.		

b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and J Significant program changes. **CHAPTER 6 (CCS) 3. Agency Requirements: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. **1. Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to		

evaluate whether implementation of improvements is working. The plan shall include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance. b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. Implementation of the ISP, including: i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.		

b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and j. Significant program changes. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above. **CHAPTER 7 (CIHS) 3. Agency Requirements: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. 1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired		

outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance. b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The		

QA/QI review should address at least the following: a. Implementation of the ISP, including: a. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and b. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed. b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and j. Significant program changes. 3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed		

items above. **CHAPTER 11 (FL) 3. Agency Requirements: H. Quality Improvement/Quality Assurance (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. 1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance; b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure		

performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. Implementation of the ISP, including: i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed. b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and		

J. Significant program changes. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above **CHAPTER 12 (SL) 3. Agency Requirements: B. Quality Assurance/Quality Improvement (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. 1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements is working. The plan shall include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and		

provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance. b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. Implementation of the ISP, including: i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed. b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements;		

e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and j. Significant program changes. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above. **CHAPTER 13 (IMLS) 3. Service Requirements: F. Quality Assurance/Quality Improvement (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Program:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. 1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to		

improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring /oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance. b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following: a. Implementation of the ISP, including: i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed.		

b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and j. Significant program changes. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above. **CHAPTER 14 (ANS) 3. Service Requirements: N. Quality Assurance/Quality Improvement (QA/QI) Program: Quality Assurance/Quality Improvement (QA/QI) Plan:** Community-based providers shall develop and maintain an active QA/QI plan in order to assure the provisions of quality services. 1. **Development of a QA/QI plan:** The QA/QI plan is used by an agency to continually determine whether the agency is performing within program requirements, achieving desired		

outcomes and identifying opportunities for improvement. The QA/QI plan describes the process the Provider Agency uses in each phase of the process: discovery, remediation and improvement. It describes the frequency, the source and types of information gathered, as well as the methods used to analyze and measure performance. The QA/QI plan must describe how the data collected will be used to improve the delivery of services and methods to evaluate whether implementation of improvements are working. The plan shall include but is not limited to: a. Activities or processes related to discovery, i.e., monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual's and provider level of service delivery. These monitoring activities provide a foundation for QA/QI plan by generating information that can be aggregated and analyzed to measure the overall system performance. b. The entities or individuals responsible for conducting the discovery/monitoring process; c. The types of information used to measure performance; and d. The frequency with which performance is measured. 2. **Implementing a QA/QI Committee:** The QA/QI committee must convene on at least a quarterly basis and as needed to review monthly service reports, to identify and remedy any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement. The QA/QI meeting must be documented. The QA/QI review should address at least the following:		

a. Implementation of the ISP, including: i. Implementation of outcomes and action steps at the required frequency outlined in the ISP; and ii. Outcome statements for each life area are measurable and can be readily determined when it is accomplished or completed. b. Compliance with Caregivers Criminal History Screening requirements; c. Compliance with Employee Abuse Registry requirements; d. Compliance with DDSD training requirements; e. Patterns in reportable incidents; f. Sufficiency of staff coverage; g. Patterns in medication errors; h. Action taken regarding individual grievances; i. Presence and completeness of required documentation; and j. Significant program changes. 3. **Preparation of the Report:** The Provider Agency must complete a QA/QI report annually from the QA/QI Plan by February 15th of each calendar year. The report must be sent to DDSD, kept on file at the agency, and made available upon request. The report will summarize the listed items above.		

NMAC 7.1.14.8 INCIDENT MANAGEMENT SYSTEM REPORTING REQUIREMENTS FOR COMMUNITY-BASED SERVICE PROVIDERS: **F. Quality assurance/quality improvement program for community-based service providers:** **F. Quality assurance/quality improvement program for community-based service providers:** The community-based service provider shall establish and implement a quality improvement program for reviewing alleged complaints and incidents of abuse, neglect, or exploitation against them as a provider after the division's investigation is complete. The incident management program shall include written documentation of corrective actions taken. The community-based service provider shall take all reasonable steps to prevent further incidents. The community-based service provider shall provide the following internal monitoring and facilitating quality improvement program: **(1)** community-based service providers shall have current abuse, neglect, and exploitation management policy and procedures in place that comply with the department's requirements; **(2)** community-based service providers providing intellectual and developmental disabilities services must have a designated incident management coordinator in place; and **(3)** community-based service providers providing intellectual and developmental disabilities services must have an incident management committee to identify any deficiencies, trends, patterns, or concerns as well as opportunities for quality improvement, address internal and external incident reports for the purpose of examining internal root causes, and to take action on identified issues.		

Tag #1A08.2 Healthcare Requirements	Standard Level Deficiency	Condition of Participation 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. Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **Chapter 5 (CIES) 3. Agency Requirements** **H. Consumer Records Policy:** All Provider Agencies must maintain at the administrative office a confidential case file for each individual. Provider agency case files for individuals are required to comply with the DDSD Consumer Records Policy.	Based on record review, the Agency did not provide documentation of annual physical examinations and/or other examinations as specified by a licensed physician for 7 of 18 individuals receiving Community Inclusion, Living Services and Other Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Inclusion Services / Other Services Healthcare Requirements (Individuals Receiving Inclusion / Other Services Only):*** • **Annual Physical** (#11) • **Dental Exam** ° Individual #11 - As indicated by the DDSD file matrix Dental Exams are to be conducted annually. No evidence of exam was found. • **Vision Exam** ° Individual #11 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ° Individual #12 - As indicated by the DDSD file matrix Vision Exams are to be conducted every other year. No evidence of exam was found. ***Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):*** • **Dental Exam** ° Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 9/30/2015. Follow-up was to be completed in 12 months. No evidence of follow-up found.	**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 of annual physical examinations and/or other examinations as specified by a licensed physician for 2 of 17 individuals receiving Community Inclusion, Living Services and Other Services. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: ***Community Living Services / Community Inclusion Services (Individuals Receiving Multiple Services):*** • **Dental Exam** ° Individual #2 - As indicated by collateral documentation reviewed, exam was completed on 9/30/2015. Follow-up was to be completed in 12 months. No evidence of follow-up found. • **Colonoscopy** ° Individual #17 - As indicated by collateral documentation reviewed, exam was to be scheduled in 6/2016. No evidence of exam results were found.

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. **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**	◦ Individual #7 - As indicated by collateral documentation reviewed, the exam was completed on 4/1/2015. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. ◦ Individual #17 - As indicated by collateral documentation reviewed, the exam was completed on 7/22/2015. As indicated by the DDSD file matrix, Dental Exams are to be conducted annually. No evidence of current exam was found. • **Vision Exam** ◦ Individual #6 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. ◦ Individual #9 - As indicated by the DDSD file matrix, Vision Exams are to be conducted every other year. No evidence of exam was found. • **Blood Levels** ◦ Individual #17 - As indicated by collateral documentation reviewed, lab work was ordered on 6/3/2016. Follow-up was to be completed in 3 months. No evidence of follow-up found. • **Colonoscopy** ◦ Individual #17 - As indicated by collateral documentation reviewed, exam was to be scheduled in 6/2016. No evidence of exam results were found. • **X-Ray** ◦ Individual #17 - As indicated by collateral documentation reviewed, the exam was completed on 5/9/2016. No evidence of exam results were found.	

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 # 1A09 Medication Delivery Routine Medication Administration	Standard Level Deficiency	Standard Level Deficiency
NMAC 16.19.11.8 MINIMUM STANDARDS: A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS: (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.	Medication Administration Records (MAR) were reviewed for the months of October and November, 2016. Based on record review, 5 of 8 individuals had Medication Administration Records (MAR), which contained missing medications entries and/or other errors: Individual #3 November 2016 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Mirtazapine 15mg tablet (1 time daily) – Blank 11/12 (8:00 PM) Individual #8 October 2016 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Flora Probiotic (2 times daily) – Blank 10/7 (8:00 PM); 10/8 (8:00 AM) • Multivitamin (1 time daily) – Blank 10/8 (8:00 AM) • Preparation H (2 times daily) – Blank 10/7 (8:00 PM); 10/8 (8:00 AM) Medication Administration Records did not contain the correct diagnosis for which the medication is prescribed: • Quetiapine 25mg (1 time daily) MAR *indicated medication was to be given for Constipation. Physician orders indicated medication was to be given for Depression.*	**New/Repeat Finding:** Medication Administration Records (MAR) were reviewed for the months of May and June, 2017. Based on record review, 4 of 8 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #3 May 2017 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Systane Ultra (2 times daily) • Vitamin D3 1000 IU (1 time daily) June 2017 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Systane Ultra (2 times daily) • Vitamin D3 1000 IU (1 time daily) Individual #9 May 2017 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Olanzapine 5mg (1 time daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Doc-Q-Lace / Docusate Sodium (2 times daily) June 2017

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 5 (CIES) 1. Scope of Service B. Self Employment 8.** Providing assistance with medication delivery as outlined in the ISP; **C. Individual Community Integrated Employment 3.** Providing assistance with medication delivery as outlined in the ISP; **D. Group Community Integrated Employment 4.** Providing assistance with medication delivery as outlined in the ISP; and **B. Community Integrated Employment Agency Staffing Requirements: o.** Comply with DDSD Medication Assessment and Delivery Policy and Procedures; **CHAPTER 6 (CCS) 1. Scope of Services A. Individualized Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **C. Small Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **D. Group Customized Community Supports 19.** Providing assistance or supports with medications in accordance with DDSD Medication Assessment and Delivery policy. **CHAPTER 11 (FL) 1 SCOPE OF SERVICES** **A. Living Supports- Family Living Services:** The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): **19.** Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-	As indicated by the Medication Administration Records the individual is to take Generlac 20 grams (2 times daily PRN). According to the Physician's Orders, Generlac 20 grams is to be taken 3 times daily. Medication Administration Record and Physician's Orders do not match. Individual #9 November 2016 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Olanzapine 5mg (1 time daily) – Blank 11/12, 13 (8:00 PM) Individual #10 November 2016 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Escitalopram 10mg tablet (1 time daily) – Blank 11/14 (8:00 AM) • Nystatin Topical Powder (4 times daily) – Blank 11/1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 13, 14 (12:00 PM); 11/1, 2, 3, 4, 7, 8, 9, 10, 11, 13, 14 (4:00 PM) Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Senexon 50mg tablet (2 times daily) – Blank 11/2 (8:00 AM); 11/10, 11 (8:00 PM) Individual #16 October 2016 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperidone 5mg (2 times daily) November 2016	Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Olanzapine 5mg (1 time daily) Medication Administration Records did not contain the strength of the medication which is to be given: • Doc-Q-Lace / Docusate Sodium (2 times daily) Individual #10 May 2017 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Chlorhexidine 0.12% Rinse (2 times daily) June 2017 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Chlorhexidine 0.12% Rinse (2 times daily) Individual #16 June 2017 Medication Administration Records contained missing entries. No documentation found indicating reason for missing entries: • Ketotifen 0.025ml (2 times daily) – Blank 6/30 (3:00 PM)

administer medication as appropriate; and **I. Healthcare Requirements for Family Living. 3. B.** Adult Nursing Services for medication oversight are required for all surrogate Living Supports-Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication. **6.** Support Living- Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations. a. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; b. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of	Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Risperidone 5mg (2 times daily) Physician's Orders indicated the following medication was to be given. The following Medication was not documented on the Medication Administration Records: • Calcium 600mg (1 time daily)	

the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. c. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and d. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications. e. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication changes to the provider agency in a timely manner to insure accuracy of the MAR. i. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments. ii. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed		

Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements. iii. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided. **CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication** Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. h. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; i. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration;		

iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. j. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and k. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse events and interactions with other medications. **CHAPTER 13 (IMLS) 2. Service Requirements.** **B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007		

CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS: **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication, diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals		

participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;		

Tag # 1A09.1 Medication Delivery PRN Medication Administration	Standard Level Deficiency	Standard Level Deficiency
NMAC 16.19.11.8 MINIMUM STANDARDS: **A. MINIMUM STANDARDS FOR THE DISTRIBUTION, STORAGE, HANDLING AND RECORD KEEPING OF DRUGS:** (d) The facility shall have a Medication Administration Record (MAR) documenting medication administered to residents, **including over-the-counter medications.** This documentation shall include: (i) Name of resident; (ii) Date given; (iii) Drug product name; (iv) Dosage and form; (v) Strength of drug; (vi) Route of administration; (vii) How often medication is to be taken; (viii) Time taken and staff initials; (ix) Dates when the medication is discontinued or changed; (x) The name and initials of all staff administering medications. **Model Custodial Procedure Manual** ***D. Administration of Drugs*** Unless otherwise stated by practitioner, patients will not be allowed to administer their own medications. Document the practitioner's order authorizing the self-administration of medications. All PRN (As needed) medications shall have complete detail instructions regarding the administering of the medication. This shall include: ➢ symptoms that indicate the use of the medication, ➢ exact dosage to be used, and ➢ the exact amount to be used in a 24-hour period.	Medication Administration Records (MAR) were reviewed for the months of October and November, 2016 Based on record review, 4 of 8 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #3 November 2016 Medication Administration Records did not contain the diagnosis for which the medication is prescribed: • Lorazepam 0.5mg tablet (PRN) Individual #8 October 2016 As indicated by the Medication Administration Records the individual is to take Generlac 20 grams (2 times daily PRN). According to the Physician's Orders, Generlac 20 grams is to be taken 3 times daily. Medication Administration Record and Physician's Orders do not match. No evidence of documented Signs/Symptoms were found for the following PRN medication: • Generlac 20 grams – PRN – 10/8 (given 1 time); 10/9 (given 2 times); 10/10 (given 2 times) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Generlac 20 grams – PRN – 10/8 (given 1 time); 10/9 (given 2 times); 10/10 (given 2 times) Individual #9	**New/Repeat Finding:** Medication Administration Records (MAR) were reviewed for the months of May and June, 2017. Based on record review, 4 of 8 individuals had PRN Medication Administration Records (MAR), which contained missing elements as required by standard: Individual #3 May 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Benadryl (PRN) • Bisacodyl (PRN) • Chloraseptic Throat Spray (PRN) • Eucerin Cream (PRN) • Ibuprofen (PRN) • Loperamide (PRN) • Loratadine (PRN) • Lorazepam 0.5mg (PRN) • Mylanta (PRN) • Polyethylene Glycol 3350 (PRN) • Pseudoephedrine (PRN) • Triple antibiotic ointment (PRN)

Department of Health Developmental Disabilities Supports Division (DDSD) Medication Assessment and Delivery Policy - Eff. November 1, 2006 **F. PRN Medication** 3. Prior to self-administration, self-administration with physical assist or assisting with delivery of PRN medications, the direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN medication is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. This does not apply to home based/family living settings where the provider is related by affinity or by consanguinity to the individual. 4. The agency nurse shall review the utilization of PRN medications routinely. Frequent or escalating use of PRN medications must be reported to the PCP and discussed by the Interdisciplinary for changes to the overall support plan (see Section H of this policy). **H. Agency Nurse Monitoring** 1. Regardless of the level of assistance with medication delivery that is required by the individual or the route through which the medication is delivered, the agency nurses must monitor the individual's response to the effects of their routine and PRN medications. The frequency and type of monitoring must be based on the nurse's assessment of the individual and consideration of the individual's diagnoses, health status, stability, utilization of PRN medications	November 2016 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Lorazepam 0.5mg – PRN – 11/6 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam 0.5mg – PRN – 11/6 (given 1 time) Individual #10 November 2016 No evidence of documented Signs/Symptoms were found for the following PRN medication: • Hydroxine 10mg – PRN – 11/1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 13 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Hydroxine 10mg – PRN – 11/1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 13 (given 1 time) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Morphine Sulfate .25mg – PRN – 11/13 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Morphine Sulfate .25mg – PRN – 11/13 (given 1 time) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Polyethylene Glycol Dosage 17 grams – PRN – 11/1, 3, 4, 7, 8, 9, 10 (given 1 time) No Effectiveness was noted on the Medication	Medication Administration Records did not contain the circumstance for which the medication is to be used: • Benadryl (PRN) • Chloraseptic (PRN) • Pseudoephedrine (PRN) • Triple antibiotic ointment (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Benadryl (PRN) • Bisacodyl (PRN) • Ibuprofen (PRN) • Loperamide (PRN) • Loratadine (PRN) • Pseudoephedrine (PRN) • Tums (PRN) June 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Benadryl (PRN) • Bisacodyl (PRN) • Chloraseptic Throat Spray (PRN) • Eucerin Cream (PRN) • Ibuprofen (PRN) • Loperamide (PRN)

and level of support required by the individual's condition and the skill level and needs of the direct care staff. Nursing monitoring should be based on prudent nursing practice and should support the safety and independence of the individual in the community setting. The health care plan shall reflect the planned monitoring of the individual's response to medication. **Department of Health Developmental Disabilities Supports Division (DDSD) - Procedure Title:** **Medication Assessment and Delivery Procedure Eff Date: November 1, 2006** C. 3. Prior to delivery of the PRN, direct support staff must contact the agency nurse to describe observed symptoms and thus assure that the PRN is being used according to instructions given by the ordering PCP. In cases of fever, respiratory distress (including coughing), severe pain, vomiting, diarrhea, change in responsiveness/level of consciousness, the nurse must strongly consider the need to conduct a face-to-face assessment to assure that the PRN does not mask a condition better treated by seeking medical attention. (References: Psychotropic Medication Use Policy, Section D, page 5 Use of PRN Psychotropic Medications; and, Human Rights Committee Requirements Policy, Section B, page 4 Interventions Requiring Review and Approval – Use of PRN Medications). a. Document conversation with nurse including all reported signs and symptoms, advice given and action taken by staff. 4. Document on the MAR each time a PRN medication is used and describe its effect on the individual (e.g., temperature down, vomiting lessened, anxiety increased, the condition is the same, improved, or worsened, etc.).	Administration Record for the following PRN medication: • Polyethylene Glycol Dosage 17 grams – PRN – 11/1, 3, 4, 7, 8, 9, 10 (given 1 time) No evidence of documented Signs/Symptoms were found for the following PRN medication: • Lorazepam 0.5mg – PRN – 11/11, 12 (given 1 time) No Effectiveness was noted on the Medication Administration Record for the following PRN medication: • Lorazepam 0.5mg – PRN – 11/11, 12 (given 1 time)	• Loratadine (PRN) • Lorazepam 0.5mg (PRN) • Mylanta (PRN) • Polyethylene Glycol 3350 (PRN) • Pseudoephedrine (PRN) • Triple antibiotic ointment (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Benadryl (PRN) • Chloraseptic (PRN) • Pseudoephedrine (PRN) • Triple antibiotic ointment (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Benadryl (PRN) • Bisacodyl (PRN) • Ibuprofen (PRN) • Loperamide (PRN) • Loratadine (PRN) • Pseudoephedrine (PRN) • Tums (PRN) Individual #9

Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) 1 SCOPE OF SERVICES** **A. Living Supports- Family Living Services:** The scope of Family Living Services includes, but is not limited to the following as identified by the Interdisciplinary Team (IDT): **19.** Assisting in medication delivery, and related monitoring, in accordance with the DDSD's Medication Assessment and Delivery Policy, New Mexico Nurse Practice Act, and Board of Pharmacy regulations including skill development activities leading to the ability for individuals to self-administer medication as appropriate; and **I. Healthcare Requirements for Family Living. 3. B.** Adult Nursing Services for medication oversight are required for all surrogate Lining Supports-Family Living direct support personnel if the individual has regularly scheduled medication. Adult Nursing services for medication oversight are required for all surrogate Family Living Direct Support Personnel (including substitute care), if the individual has regularly scheduled medication. **6.** Support Living- Family Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the New Mexico Nurse Practice Act and Board of Pharmacy standards and regulations. f. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; g. When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include:		May 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Lorazepam 0.5mg (PRN) • Bisacodyl EC 5mg (PRN) June 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Lorazepam 0.5mg (PRN) • Bisacodyl EC 5mg (PRN) Individual #10 May 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Aleve (PRN) • Lorazepam (PRN) • Milk of Magnesia 400ml (PRN) • Morphine 25mgml (PRN) • Albuterol (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Aleve (PRN) • Milk of Magnesia 400ml (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Aleve (PRN) • Lorazepam (PRN)

i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. h. The Family Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and i. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administering the medication, signs and symptoms of adverse events and interactions with other medications. j. Medication Oversight is optional if the individual resides with their biological family (by affinity or consanguinity). If Medication Oversight is not selected as an Ongoing Nursing Service, all elements of medication administration and oversight are the sole responsibility of the individual and their biological family. Therefore, a monthly medication administration record (MAR) is not required unless the family requests it and continually communicates all medication		• Albuterol (PRN) June 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Aleve (PRN) • Lorazepam (PRN) • Milk of Magnesia 400ml (PRN) • Morphine 25mgml (PRN) • Albuterol (PRN) Medication Administration Records did not contain the circumstance for which the medication is to be used: • Aleve (PRN) • Milk of Magnesia 400ml (PRN) • Triple Antibiotic Ointment (PRN) Medication Administration Records did not contain the strength of the medication which is to be given: • Aleve (PRN) • Lorazepam (PRN) • Albuterol (PRN) Individual #16 May 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period: • Albuterol-Sulfate (PRN) June 2017 Medication Administration Records did not contain the exact amount to be used in a 24-hour period:

changes to the provider agency in a timely manner to insure accuracy of the MAR. iv. The family must communicate at least annually and as needed for significant change of condition with the agency nurse regarding the current medications and the individual's response to medications for purpose of accurately completing required nursing assessments. v. As per the DDSD Medication Assessment and Delivery Policy and Procedure, paid DSP who are not related by affinity or consanguinity to the individual may not deliver medications to the individual unless they have completed Assisting with Medication Delivery (AWMD) training. DSP may also be under a delegation relationship with a DDW agency nurse or be a Certified Medication Aide (CMA). Where CMAs are used, the agency is responsible for maintaining compliance with New Mexico Board of Nursing requirements. vi. If the substitute care provider is a surrogate (not related by affinity or consanguinity) Medication Oversight must be selected and provided. **CHAPTER 12 (SL) 2. Service Requirements L. Training and Requirements: 3. Medication** Delivery: Supported Living Provider Agencies must have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, New Mexico Nurse Practice Act, and Board of Pharmacy standards and regulations. l. All twenty-four (24) hour residential home sites serving two (2) or more unrelated individuals must be licensed by the Board of Pharmacy, per current regulations; m. When required by the DDSD Medication		• Albuterol-Sulfate (PRN)

Assessment and Delivery Policy, Medication Administration Records (MAR) must be maintained and include: i. The name of the individual, a transcription of the physician's or licensed health care provider's prescription including the brand and generic name of the medication, and diagnosis for which the medication is prescribed; ii. Prescribed dosage, frequency and method/route of administration, times and dates of administration; iii. Initials of the individual administering or assisting with the medication delivery; iv. Explanation of any medication error; v. Documentation of any allergic reaction or adverse medication effect; and vi. For PRN medication, instructions for the use of the PRN medication must include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. n. The Supported Living Provider Agency must also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; and o. Information from the prescribing pharmacy regarding medications must be kept in the home and community inclusion service locations and must include the expected desired outcomes of administrating the medication, signs, and symptoms of adverse		

events and interactions with other medications. **CHAPTER 13 (IMLS) 2. Service Requirements.** **B.** There must be compliance with all policy requirements for Intensive Medical Living Service Providers, including written policy and procedures regarding medication delivery and tracking and reporting of medication errors consistent with the DDSD Medication Delivery Policy and Procedures, relevant Board of Nursing Rules, and Pharmacy Board standards and regulations. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:** The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards. **E. Medication Delivery:** Provider Agencies that provide Community Living, Community Inclusion or Private Duty Nursing services shall have written policies and procedures regarding medication(s) delivery and tracking and reporting of medication errors in accordance with DDSD Medication Assessment and Delivery Policy and Procedures, the Board of Nursing Rules and Board of Pharmacy standards and regulations. (2) When required by the DDSD Medication Assessment and Delivery Policy, Medication Administration Records (MAR) shall be maintained and include: (a) The name of the individual, a transcription of the physician's written or licensed health care provider's prescription including the brand and generic name of the medication,		

diagnosis for which the medication is prescribed; (b) Prescribed dosage, frequency and method/route of administration, times and dates of administration; (c) Initials of the individual administering or assisting with the medication; (d) Explanation of any medication irregularity; (e) Documentation of any allergic reaction or adverse medication effect; and (f) For PRN medication, an explanation for the use of the PRN medication shall include observable signs/symptoms or circumstances in which the medication is to be used, and documentation of effectiveness of PRN medication administered. (3) The Provider Agency shall also maintain a signature page that designates the full name that corresponds to each initial used to document administered or assisted delivery of each dose; (4) MARs are not required for individuals participating in Independent Living who self-administer their own medications; (5) Information from the prescribing pharmacy regarding medications shall be kept in the home and community inclusion service locations and shall include the expected desired outcomes of administrating the medication, signs and symptoms of adverse events and interactions with other medications;		

Tag # 1A15.2 and IS09 / 5I09 Healthcare Documentation	Standard Level Deficiency	Condition of Participation Level
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **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.	Based on record review, the Agency did not maintain the required documentation in the Individuals Agency Record as required by standard for 5 of 18 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) (#7) • Comprehensive Aspiration Risk Management Plan: ➢ Not Current (#6) • **Semi-Annual Nursing Review of HCP/Medical Emergency Response Plans:** • None found for 7/2015 – 12/2015 *(Term of ISP 7/1/2015 – 6/30/2016).* (#2) • None found for 5/2015 – 11/2015 and 12/2015 – 2/2016 *(Term of ISP 5/30/2015 – 5/29/2016 and 5/30/2016 – 5/29/2017) (ISP meeting held 3/3/2016).* (#6) • None found for 6/2015 - 8/2015 *(Report covered 9/2015 – 3/2016) (Term of ISP 6/23/2015 – 6/22/2016) (ISP meeting held 3/3/2016) (Per regulations reports must coincide with ISP term.)* (#7) • None found for 10/2015 – 1/2016 *(Term of ISP 4/26/2015 – 4/25/2016) (ISP meeting held 1/21/2016).* (#18)	**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 the required documentation in the Individual's Agency Record as required by standard for 1 of 17 individuals. Review of the administrative individual case files revealed the following items were not found, incomplete, and/or not current: • Comprehensive Aspiration Risk Management Plan: ➢ Not Current (#6)

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 staff, family members or other team members; objective information including vital signs, physical		

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

progress notes with date and time indicated that describe all interventions or interactions conducted with individuals served, as well as all interactions with other healthcare providers serving the individual. All interactions must be documented whether they occur by phone or in person; and d. Document for each individual that: i. The individual has a Primary Care Provider (PCP); ii. The individual receives an annual physical examination and other examinations as specified by a PCP; iii. The individual receives annual dental check-ups and other check-ups as specified by a licensed dentist; iv. The individual receives a hearing test as specified by a licensed audiologist; v. The individual receives eye examinations as specified by a licensed optometrist or ophthalmologist; and vi. Agency activities occur as required for follow-up activities to medical appointments (e.g. treatment, visits to specialists, and changes in medication or daily routine). 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 a current orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 15 of 18 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, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18)	**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 a current orientation packet including incident management system policies and procedural information concerning the reporting of Abuse, Neglect and Exploitation, for 9 of 17 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) (# 2, 8, 10, 11, 12, 13, 14, 16, 18)

Tag # LS06 / 6L06 Family Living Requirements	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 12 (FL) I. Living Supports – Family Living Home Studies:** The Living Supports-Family Living Services Provider Agency must complete all Developmental Disabilities Support Division (DDSD) requirements for approval of each direct support provider, including completion of an approved home study and training of the direct support provider prior to placement. After the initial home study, an updated home study must be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies must be approved by DDSD. **2. Service Requirements:** **E. Supervision:** The Living Supports- Family Living Provider Agency must provide and document: 1. Monthly face to face consultation, by agency supervisors or internal service coordinators, with the DSP on at least a monthly basis to include: a. Review implementation of the individual's ISP Action Plans and associated support plans, including, Positive Behavior Support Plan (PBSP), Written Direct Support Instructions, (WDSI) from therapist(s) serving the individual, schedule of activities and appointments; and advise direct support personnel regarding expectations and next steps including need for individual specific training or retraining from therapists and Behavior Support Consultants;	Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 4 of 9 individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current: • Family Living (Annual Update) Home Study ° Individual #1 – Not Dated. ° Individual #6 – Not Dated. ° Individual #16 - Not Found. ° Individual #18 - Not Found.	**Repeat Finding:** Based on record review, the Agency did not complete all DDSD requirements for approval of each direct support provider for 3 of 8 individuals. Review of the Agency files revealed the following items were not found, incomplete, and/or not current: • Family Living (Annual Update) Home Study ° Individual #6 – Not Dated. ° Individual #16 - Not Found. ° Individual #18 - Not Found.

b. Review implementation and the effectiveness of therapy, healthcare, PBSP, Behavior Crisis Intervention Plan (BCIP), MERP, and Comprehensive Aspiration Risk Management Plan (CARMP) plans if applicable; c. Assist with resolution of service or support issues raised by the DSP or observed by the supervisor, service coordinator or other IDT members; and d. Monitor the Assistive Technology Inventory to ensure that needed adaptive equipment, augmentative communication and assistive technology devices are available and functioning properly. Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **CHAPTER 6. III. REQUIREMENTS UNIQUE TO FAMILY LIVING SERVICES** **A**. **Support to Individuals in Family Living:** The Family Living Services Provider Agency shall provide and document: (5) Monthly consultation, by agency supervisors or internal service coordinators, with the direct support provider to include: (a) Review, advise, and prompt the implementation of the individual's ISP Action Plans, schedule of activities and appointments; and (b) Assist with service or support issues raised by the direct support provider or observed by supervisor, service coordinator or other IDT members. **B**. **Home Studies**. The Family Living Services Provider Agency shall complete all DDSD		

requirements for approval of each direct support provider, including completion of an approved home study and training prior to placement. After the initial home study, an updated home study shall be completed annually. The home study must also be updated each time there is a change in family composition or when the family moves to a new home. The content and procedures used by the Provider Agency to conduct home studies shall be approved by DDSD. **NMAC 8.314.5.10 - DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES WAIVER** **ELIGIBLE PROVIDERS:** I. **Qualifications for community living service providers:** There are three types of community living services: Family living, supported living and independent living. Community living providers must meet all qualifications set forth by the DOH/DDSD, DDW definitions and service standards. (1) Family living service providers for adults must meet the qualifications for staff required by the DOH/DDSD, DDW service definitions and standards. The direct care provider employed by or subcontracting with the provider agency must be approved through a home study completed prior to provision of services and conducted at subsequent intervals required of the provider agency. All family living sub-contracts must be approved by the DOH/DDSD.		

Tag # LS25 / 6L25 Residential Health and Safety (SL/FL)	Standard Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards effective 11/1/2012 revised 4/23/2013; 6/15/2015 **CHAPTER 11 (FL) Living Supports – Family Living Agency Requirements G. Residence Requirements for Living Supports- Family Living Services:** 1. Family Living Services providers must assure that each individual's residence is maintained to be clean, safe and comfortable and accommodates the individuals' daily living, social and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Have a battery operated or electric smoke detectors, carbon monoxide detectors, fire extinguisher, or a sprinkler system; d. Have a general-purpose first aid kit; e. Allow at a maximum of two (2) individuals to share, with mutual consent, a bedroom and each individual has the right to have his or her own bed; f. Have accessible written documentation of actual evacuation drills occurring at least three (3) times a year; g. Have accessible written procedures for the safe	Based on observation, the Agency did not ensure that each individuals' residence met all requirements within the standard for 10 of 10 Supported Living and Family Living residences. Review of the residential records and observation of the residence revealed the following items were not found, not current, not functioning or incomplete: **Supported Living Requirements:** • Water temperature in home does not exceed safe temperature (110^0 F) ➢ Water temperature in home measured 117.5^0 F (#3, 9, 10) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#3, 9, 10) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#3, 9, 10) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#3, 9, 10) *Note: The following Individuals share a residence:* ➢ #3, 9, 10 **Family Living Requirements:** • Battery operated or electric smoke detectors	**Repeat Finding:** Based on the Plan of Correction approved on 4/14/2017, "All deficiencies cited in the tag have been corrected." The Agency did not ensure that each individuals' residence met all requirements within the standard for 8 of 9 Supported Living and Family Living residences. Review of records revealed the following items had not been addressed: **Supported Living Requirements:** • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#3, 9, 10) *Note: The following Individuals share a residence:* ➢ #3, 9, 10 **Family Living Requirements:** • Battery operated or electric smoke detectors installed in the residence (#2, 17) • General-purpose first aid kit (#1, 2) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2, 6, 8, 15, 17, 18)

storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Delivery training or each individual's ISP; and h. Have accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures must address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding. **CHAPTER 12 (SL) Living Supports – Supported Living Agency Requirements G. Residence Requirements for Living Supports-Supported Living Services:** 1. Supported Living Provider Agencies must assure that each individual's residence is maintained to be clean, safe, and comfortable and accommodates the individual's daily living, social, and leisure activities. In addition, the residence must: a. Maintain basic utilities, i.e., gas, power, water, and telephone; b. Provide environmental accommodations and assistive technology devices in the residence including modifications to the bathroom (i.e., shower chairs, grab bars, walk in shower, raised toilets, etc.) based on the unique needs of the individual in consultation with the IDT; c. Ensure water temperature in home does not exceed safe temperature (110^0 F); d. Have a battery operated or electric smoke detectors and carbon monoxide detectors, fire extinguisher, or a sprinkler system; e. Have a general-purpose First Aid kit;	installed in the residence (#2, 17) • General-purpose first aid kit (#1, 2) • Accessible written procedures for emergency evacuation e.g. fire and weather-related threats (#1, 2, 6, 7, 8, 15, 16) • Accessible written procedures for the safe storage of all medications with dispensing instructions for each individual that are consistent with the Assisting with Medication Administration training or each individual's ISP (#1, 2, 6, 7, 8, 15, 17, 18) • Accessible written procedures for emergency placement and relocation of individuals in the event of an emergency evacuation that makes the residence unsuitable for occupancy. The emergency evacuation procedures shall address, but are not limited to, fire, chemical and/or hazardous waste spills, and flooding (#1, 2, 7, 8, 15, 16, 18)	

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

utensils, adequate food and drink for three meals per day, proper food storage, and cleaning supplies. T Each residence shall have a blood borne pathogens kit as applicable to the residents' health status, personal protection equipment, and any ordered or required medical supplies shall also be available in the home. U If not medically contraindicated, and with mutual consent, up to two (2) individuals may share a single bedroom. Each individual shall have their own bed. All bedrooms shall have doors that may be closed for privacy. Individuals have the right to decorate their bedroom in a style of their choosing consistent with safe and sanitary living conditions. V For residences with more than two (2) residents, there shall be at least two (2) bathrooms. Toilets, tubs/showers used by the individuals shall provide for privacy and be designed or adapted for the safe provision of personal care. Water temperature shall be maintained at a safe level to prevent injury and ensure comfort and shall not exceed one hundred ten (110) degrees.		

Standard of Care	Routine Survey Deficiencies November 11 – 17, 2016	Verification Survey New and Repeat Deficiencies August 7 – 11, 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 # 1A08.1 **Agency Case File - Progress Notes**	**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 implement 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 # 1A26 **Consolidated On-line Registry** **Employee Abuse Registry**	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A28.1 Incident Mgt. System - **Personnel Training**	**Condition of Participation Level**	**COMPLETE**
Tag # 1A36 **Service Coordination Requirements**	**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 # 1A33 Board of Pharmacy – Med. **Storage**	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag # 5I44 **Adult Habilitation Reimbursement**	**Standard Level Deficiency**	**COMPLETE**
Tag # IS30 **Customized Community Supports** **Reimbursement**	**Standard Level Deficiency**	**COMPLETE**
Tag # LS26 / 6L26 **Supported Living Reimbursement**	**Standard Level Deficiency**	**COMPLETE**
Tag # LS27 / 6L27 **Family Living Reimbursement**	**Standard Level Deficiency**	**COMPLETE**
Tag # IH32 **Customized In-Home Supports** **Reimbursement**	**Standard Level Deficiency**	**COMPLETE**

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #1A08 **Agency Case File**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	
Tag #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?)***:** →	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #LS14 / 6L14 Residential Case File	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	
Tag #LS17 / 6L17 Reporting Requirements (Community Living Reports)	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #IH17 **Reporting Requirements (Customized In-Home Supports)**	**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 #1A20 **Direct Support Personnel Training**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
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 #1A37 **Individual Specific 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?)***:** →	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #1A43 **General Events Reporting**	**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 #1A03 **CQI System**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #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 #1A09 **Medication Delivery** **Routine Medication Administration**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***:** → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***:** →	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #1A09.1 **Medication Delivery PRN Medication Administration**	**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?)***: →**	

Agency Plan of Correction		
Tag #	**Corrective Action for survey deficiencies / On-going QA/QI and Responsible Party**	**Due Date**
Tag #1A28.2 Incident Management 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 #LS06 / 6L06 Family Living 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?)***:** →	

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

Date: November 29, 2017

To: Michelle Bishop-Couch, Chief Executive Officer
Provider: Cornucopia Adult and Family Services, Inc.
Address: 2002 Bridge Blvd. SW
City/State/Zip: Albuquerque, New Mexico 87105

E-Mail Address michelle@cornucopia-ads.org

CC: Michelle M. Mullen, President
Address: 1718 Central Avenue Southwest Suite D
City/State/Zip: Albuquerque, New Mexico 87104

E-mail Address: michele@mullenheller.com

Region: Metro
Routine Survey: November 11 – 17, 2016
Verification Survey: August 7 – 11, 2017
Program Surveyed: Developmental Disabilities Waiver

Dear Ms. Bishop-Couch;

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.18.1.DDW.D3796.5.VER.09.17.333