Date:	December 27, 2018
To:	Jason Buckles, Executive Director
Provider:	A Better Way of Living, Inc.
Address:	202 Central Ave SE Suite 200
State/Zip:	Albuquerque, New Mexico 87102
E-mail Address:	JasonB@ABetterWayNM.org
Region:	Metro
Routine Survey:	May 11 – 18, 2018
Verification Survey:	November 14 – 30, 2018
Service Surveyed:	***2007:*** Independent Living and Supported Employment ***2012:*** Supported Living, Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports
Survey Type:	Verification
Team Leader:	Amanda Castañeda, MPA, Plan of Correction Coordinator, Division of Health Improvement/Quality Management Bureau

Dear Mr. Buckles;

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* May 11 – 18, 2018.

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

Compliance: This determination is based on your agency's compliance with Condition of Participation level and Standard level requirements. Deficiencies found only affect a small percentage of the Individuals on the survey sample *(refer to Attachment B for details)*. The attached QMB Report of Findings indicates Standard Level deficiencies identified and requires implementation of a Plan of Correction.

The following tags are identified as Standard Level:

- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation
- Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*
- Tag # 1A26 Consolidated On-line Registry / Employee Abuse Registry
- Tag # 1A43.1 General Events Reporting: Individual Reporting

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

Plan of Correction:

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

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

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

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

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

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

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

Sincerely,

Amanda Castañeda

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

Survey Process Employed:

Administrative Review Start Date:	November 14, 2018
Contact:	**A Better Way of Living, Inc,** Jason Buckles, Executive Director **DOH/DHI/QMB** Amanda Castañeda, MPA, Team Lead/Plan of Correction Coordinator
Total Sample Size:	15 1 - *Jackson* Class Members 14 - Non-*Jackson* Class Members 10 - Supported Living 1 - Independent Living 4 - Customized In-Home Supports 7 - Customized Community Supports 10 - Community Integrated Employment 1 - Supported Employment

Persons Served Records Reviewed	15
Direct Support Personnel Records Reviewed	96
Direct Support Personnel Interviewed during Routine Survey	17
Substitute Care/Respite Personnel Records Reviewed	1
Service Coordinator Records Reviewed	5
Administrative Interviews	1

Administrative Processes and Records Reviewed:

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

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 other state and federal regulations. For the purpose of the LCA / CI survey the CMS waiver assurances have been grouped into four (4) Service Domains: Plan of Care (ISP Implementation); 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 Assurance 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 during the on-site survey process and as reported in the QMB Report of Findings. All areas reviewed by QMB have been agreed to by DDSD and DHI/QMB and are reflective of CMS requirements. 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.

Each deficiency in your Report of Findings has been predetermined to be a Standard Level Deficiency, a Condition of Participation Level Deficiency, if below 85% compliance or a non-negotiable Condition of Participation Level Deficiency. Your Agency's overall Compliance Determination is based on a Scope and Severity Scale which takes into account the number of Standard and Condition Level Tags cited as well as the percentage of Individuals affected in the sample.

Conditions of Participation (CoPs)

CoPs are based on the Centers for Medicare and Medicaid Services, Home and Community-Based Waiver required assurances, in addition to the New Mexico Developmental Disability Waiver (DDW) Service Standards. The Division of Health Improvement (DHI), in conjunction with the Developmental Disability Support Division (DDSD), has identified certain deficiencies that have the potential to be a Condition of Participation Level, if the tag falls below 85% compliance based on the number of people affected. Additionally, there are what are called non-negotiable Conditions of Participation, regardless if one person or multiple people are affected. In this context, a CoP is defined as an essential / fundamental regulation or standard, which when out of compliance directly affects the health and welfare of the Individuals served. If no deficiencies within a Tag are at the level of a CoP, it is cited as a Standard Level Deficiency.

Service Domains and CoPs for <u>Living Care Arrangements and Community Inclusion</u> are as follows:

<u>Service Domain: Service Plan: ISP Implementation -</u> *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A08.3 –** Administrative Case File: Individual Service Plan / ISP Components
- **1A32 –** Administrative Case File: Individual Service Plan Implementation
- **LS14 –** Residential Service Delivery Site Case File (ISP and Healthcare Requirements)
- **IS14 –** CCS / CIES Service Delivery Site Case File (ISP and Healthcare Requirements)

<u>Service Domain: Qualified Providers -</u> *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*

Potential Condition of Participation Level Tags, if compliance is below 85%:

- **1A20 -** Direct Support Personnel Training

- **1A22 -** Agency Personnel Competency
- **1A37 –** Individual Specific Training

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A25.1 –** Caregiver Criminal History Screening
- **1A26.1 –** Consolidated On-line Registry Employee Abuse Registry

Service Domain: Health, Welfare and Safety - *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.*

Potential Condition of Participation Level Tags, if compliance is below 85%:
- **1A08.2 –** Administrative Case File: Healthcare Requirements & Follow-up
- **1A09 –** Medication Delivery Routine Medication Administration
- **1A09.1 –** Medication Delivery PRN Medication Administration
- **1A15.2 –** Administrative Case File: Healthcare Documentation (Therap and Required Plans)

Non-Negotiable Condition of Participation Level Tags (one or more Individuals are cited):
- **1A05 –** General Requirements / Agency Policy and Procedure Requirements
- **1A07 –** Social Security Income (SSI) Payments
- **1A09.2 –** Medication Delivery Nurse Approval for PRN Medication
- **1A15 –** Healthcare Documentation - Nurse Availability
- **1A31 –** Client Rights/Human Rights
- **LS25.1 –** Residential Reqts. (Physical Environment - Supported Living / Family Living / Intensive Medical Living)

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: https://nmhealth.org/about/dhi/cbp/irf/
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.

Attachment D

QMB Determinations of Compliance

Compliance:

The QMB determination of *Compliance* indicates that a provider has either no deficiencies found during a survey or has no deficiencies at the Condition of Participation Level. 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*, the provider must have received no Conditions of Participation Level Deficiencies and have a minimal number of Individuals on the sample affected by the findings indicated in the Standards Level Tags.

Partial-Compliance with Standard Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags* indicates that a provider is in compliance with all Condition of Participation Level deficiencies but is out of compliance with a certain percentage of Standard Level deficiencies. This partial-compliance, if not corrected, may result in a negative outcome or the potential for more than minimal harm to individuals' health and safety. There are two ways to receive a determination of Partial Compliance with Standard Level Tags:

1. Your Report of Findings includes 16 or fewer Standards Level Tags with between 75% and 100% of the survey sample affected in any tag.

2. Your Report of Findings includes 17 or more Standard Level Tags with between 50% to 74% of the survey sample affected in any tag.

Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags:

The QMB determination of *Partial-Compliance with Standard Level Tags and Condition of Participation Level Tags* indicates that a provider is out of compliance with one to five (1 – 5) Condition of Participation Level Tags. 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.

Non-Compliance:

The QMB determination of *Non-Compliance* indicates a provider is significantly out of compliance with both Standard Level deficiencies and Conditions of Participation level deficiencies. 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. There are three ways an agency can receive a determination of Non-Compliance:

1. Your Report of Findings includes 17 or more Standard Level Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any tag.

2. Your Report of Findings includes any amount of Standard Level Tags with 6 or more Condition of Participation Level Tags.

Compliance Determination	Weighting						
	LOW		MEDIUM			HIGH	
Standard Level Tags:	up to 16	17 or more	up to 16	17 or more	Any Amount	17 or more	Any Amount
	and	and	and	and	And/or	and	And/or
COP Level Tags:	0 COP	0 COP	0 COP	0 COP	1 to 5 COP	0 to 5 CoPs	6 or more COP
	and	and	and	and		and	
Sample Affected:	0 to 74%	0 to 49%	75 to 100%	50 to 74%		75 to 100%	
"Non-Compliance"						**17 or more** Standard Level Tags with **75 to 100%** of the Individuals in the sample cited in any tag.	**Any Amount** of Standard Level Tags and **6 or more** Conditions of Participation Level Tags.
"Partial Compliance with Standard Level tags and Condition of Participation Level Tags"					**Any Amount** of Standard level Tags, plus **1 to 5** Conditions of Participation Level tags.		
"Partial Compliance with Standard Level tags"			**up to 16** Standard Level Tags with **75 to 100%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **50 to 74%** of the individuals in the sample cited any tag.			
"Compliance"	**Up to 16** Standard Level Tags with **0 to 74%** of the individuals in the sample cited in any tag.	**17 or more** Standard Level Tags with **0 to 49%** of the individuals in the sample cited in any tag.					

Agency: **A Better Way of Living, Inc. - Metro Region**
Program: Developmental Disabilities Waiver
Service: ***2007:*** Independent Living and Supported Employment
2012: Supported Living, Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports
Survey Type: Verification
Routine Survey: **May 11 – 18, 2018**
Verification Survey: **November 14 – 30, 2018**

Standard of Care	Routine Survey Deficiencies May 11 – 18, 2018	Verification Survey New and Repeat Deficiencies November 14 – 30, 2018
Service Domain: Service Plans: ISP Implementation – *Services are delivered in accordance with the service plan, including type, scope, amount, duration and frequency specified in the service plan.*		
Tag # 1A32 Administrative Case File: Individual Service Plan Implementation	**Standard Level Deficiency** *(Modified as result of Pilot 1)*	**Standard Level Deficiency**
NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain. A. Demographic information: The individual's name, age, date of birth, important identification numbers (i.e., Medicaid, Medicare, social security numbers), level of care address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance. B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community. C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of	Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 15 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Supported Employment Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #3 • No Outcomes or DDSD exemption/decision justification found for Supportive Employment Services. As indicated by NMAC 7.26.5.14 "Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver."	**New / Repeat Finding:** Based on administrative record review, the Agency did not implement the ISP according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan for 1 of 15 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 #9

needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. **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		• None found regarding: Fun Outcome/Action Step: "With staff assistance… will coordinate transportation to Special Olympics activities" for 10/2018. Action step is to be completed weekly. • None found regarding: Live Outcome/Action Step: "… will compare generic versus name brand" for 10/2018. Action step is to be completed two times per month. • None found regarding: Live Outcome/Action Step: "… will make purchases" for 10/2018. Action step is to be completed ongoing.

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] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and		

maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 1. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 2. Provider Agencies must have readily accessible records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 3. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 4. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 5. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 6. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 7. All records pertaining to JCMs must be retained permanently and must be made available to DDSD		

upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.		

Tag # 1A32.1 Administrative Case File: Individual Service Plan Implementation *(Not Completed at Frequency)*	Standard Level Deficiency	Standard Level Deficiency
NMAC 7.26.5.14 DEVELOPMENT OF THE INDIVIDUAL SERVICE PLAN (ISP) - CONTENT OF INDIVIDUAL SERVICE PLANS: Each ISP shall contain. A. Demographic information: The individual's name, age, date of birth, important identification numbers (i.e., Medicaid, Medicare, social security numbers), level of care address, phone number, guardian information (if applicable), physician name and address, primary care giver or service provider(s), date of the ISP meeting (either annual, or revision), scheduled month of next annual ISP meeting, and team members in attendance. B. Long term vision: The vision statement shall be recorded in the individual's actual words, whenever possible. For example, in a long term vision statement, the individual may describe him or herself living and working independently in the community. C. Outcomes: (1) The IDT has the explicit responsibility of identifying reasonable services and supports needed to assist the individual in achieving the desired outcome and long term vision. The IDT determines the intensity, frequency, duration, location and method of delivery of needed services and supports. All IDT members may generate suggestions and assist the individual in communicating and developing outcomes. Outcome statements shall also be written in the individual's own words, whenever possible. Outcomes shall be prioritized in the ISP. (2) Outcomes planning shall be implemented in one or more of the four "life areas" (work or leisure activities, health or development of relationships) and address as appropriate home environment, vocational, educational, communication, self-care, leisure/social, community resource use, safety, psychological/behavioral and medical/health outcomes. The IDT shall assure that the outcomes in the ISP	Based on administrative 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 6 of 15 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 #11 • According to the Live Outcome; Action Step for "…will review his medications" is to be completed 2 times per day. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 – 3//2018. Individual #13 • According to the Live Outcome; Action Step for "…will track his income and expenses" 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 1/2018 – 3//2018. • According to the Live Outcome; Action Step for "…will purchase personal supplies" is to be	**New / Repeat Finding:** Based on administrative 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 15 individuals. As indicated by Individuals ISP the following was found with regards to the implementation of ISP Outcomes: **Administrative Files Reviewed:** **Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #10 • According to the Work/Learn Outcome; Action Step for "…will work on getting to her job on time (M - F)" is to be completed Monday through Friday. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 9/2018 - 10/2018. **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #11 • According to the Live Outcome; Action Step for "…will compare the medication names letter by letter" is to be completed 2 times per day. Evidence found indicated it was not being

relate to the individual's long term vision statement. Outcomes are required for any life area for which the individual receives services funded by the developmental disabilities Medicaid waiver. **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	completed 1 time per month. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 – 3//2018. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #9 • According to the Live Outcome; Action Step for "…will get recipe of the side dish she wants to prepare" 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 1/2018 – 3/2018. • According to the Live Outcome; Action Step for "…will prepare the side meal" 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 1/2018 – 3/2018. **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #8 • According to the Live Outcome; Action Step for "I will call my CIHS to schedule assistance with shopping and laundry" 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 1/21/2018 - 3/30/2018. • According to the Live Outcome; Action Step for "I will schedule transportation needs with my CIHS staff" is to be completed 1 time per week.	completed at the required frequency as indicated in the ISP for 9/2018 – 10//2018.

individuals with developmental disabilities. [05/03/94; 01/15/97; Recompiled 10/31/01] Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 6: Individual Service Plan (ISP)** **6.8 ISP Implementation and Monitoring:** All DD Waiver Provider Agencies with a signed SFOC are required to provide services as detailed in the ISP. The ISP must be readily accessible to Provider Agencies on the approved budget. (See Chapter 20: Provider Documentation and Client Records.) CMs facilitate and maintain communication with the person, his/her representative, other IDT members, Provider Agencies, and relevant parties to ensure that the person receives the maximum benefit of his/her services and that revisions to the ISP are made as needed. All DD Waiver Provider Agencies are required to cooperate with monitoring activities conducted by the CM and the DOH. Provider Agencies are required to respond to issues at the individual level and agency level as described in Chapter 16: Qualified Provider Agencies. **Chapter 20: Provider Documentation and Client Records: 20.2 Client Records Requirements:** All DD Waiver Provider Agencies are required to create and maintain individual client records. The contents of client records vary depending on the unique needs of the person receiving services and the resultant information produced. The extent of documentation required for individual client records per service type depends on the location of the file, the type of service being provided, and the information necessary. DD Waiver Provider Agencies are required to adhere to the following: 8. Client records must contain all documents essential to the service being provided and essential to ensuring the health and safety of the person during the provision of the service. 9. Provider Agencies must have readily accessible	Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/21/2018 - 3/30/2018. Individual #10 • According to the Live Outcome; Action Step for "… will practice words, numbers and phrases" 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 1/2018. **Community Integrated Employment Services Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #7 • According to the Work/Learn Outcome; Action Step for "…will complete work task without help for 15 minutes" 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 2/2018 - 3/2018. • According to the Work/Learn Outcome; Action Step for "…will complete work task without help for 30 minutes" 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 2/2018 - 3/2018. • According to the Work/Learn Outcome; Action Step for "…will complete work task without help for 45 minutes" 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 2/2018 - 3/2018.	

records in home and community settings in paper or electronic form. Secure access to electronic records through the Therap web based system using computers or mobile devices is acceptable. 10. Provider Agencies are responsible for ensuring that all plans created by nurses, RDs, therapists or BSCs are present in all needed settings. 11. Provider Agencies must maintain records of all documents produced by agency personnel or contractors on behalf of each person, including any routine notes or data, annual assessments, semi-annual reports, evidence of training provided/received, progress notes, and any other interactions for which billing is generated. 12. Each Provider Agency is responsible for maintaining the daily or other contact notes documenting the nature and frequency of service delivery, as well as data tracking only for the services provided by their agency. 13. The current Client File Matrix found in Appendix A Client File Matrix details the minimum requirements for records to be stored in agency office files, the delivery site, or with DSP while providing services in the community. 14. All records pertaining to JCMs must be retained permanently and must be made available to DDSD upon request, upon the termination or expiration of a provider agreement, or upon provider withdrawal from services.	• According to the Work/Learn Outcome; Action Step for "…will complete work task without help for 1 hour" 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 2/2018 - 3/2018. Individual #10 • According to the Work/Learn Outcome; Action Step for ""With prompts, … will practice inquiring with office staff about task that needs to be done on each shift" is to be completed Monday - Friday. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018 - 3/2018. • According to the Work/Learn Outcome; Action Step for ""With assistance, … will complete the task requested of her" is to be completed Monday - Friday. Evidence found indicated it was not being completed at the required frequency as indicated in the ISP for 1/2018.	

Standard of Care	Routine Survey Deficiencies May 11 – 18, 2018	Verification Survey New and Repeat Deficiencies November 14 – 30, 2018
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**N/A**	**Standard Level Deficiency**
NMAC 7.1.12.8 - REGISTRY ESTABLISHED; PROVIDER INQUIRY REQUIRED: Upon the effective date of this rule, the department has established and maintains an accurate and complete electronic registry that contains the name, date of birth, address, social security number, and other appropriate identifying information of all persons who, while employed by a provider, have been determined by the department, as a result of an investigation of a complaint, to have engaged in a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. Additions and updates to the registry shall be posted no later than two (2) business days following receipt. Only department staff designated by the custodian may access, maintain and update the data in the registry. A. **Provider requirement to inquire of registry**. A provider, prior to employing or contracting with an employee, shall inquire of the registry whether the individual under consideration for employment or contracting is listed on the registry. B. **Prohibited employment.** A provider may not employ or contract with an individual to be an employee if the individual is listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation of a person receiving care or services from a provider. C. **Applicant's identifying information required**. In making the inquiry to the registry prior to employing or contracting with an employee, the provider shall use identifying information concerning the individual under consideration for employment or contracting sufficient to reasonably and completely search the registry,	**N/A**	**New Finding:** Based on record review, the Agency did not maintain documentation in the employee's personnel records that evidenced inquiry into the Employee Abuse Registry prior to employment for 4 of 102 Agency Personnel. **The following Agency Personnel records contained evidence that indicated the Employee Abuse Registry check was completed after hire:** **Direct Support Personnel (DSP):** • #613 – Date of hire 9/25/2018, completed 9/26/2018. • #615 – Date of hire 5/30/2018, completed 6/21/2018. • #616 – Date of hire 8/10/2018, completed 8/20/2018. • #620 – Date of hire 7/11/2018, completed 7/12/2018.

including the name, address, date of birth, social security number, and other appropriate identifying information required by the registry. D. **Documentation of inquiry to registry**. The provider shall maintain documentation in the employee's personnel or employment records that evidences the fact that the provider made an inquiry to the registry concerning that employee prior to employment. Such documentation must include evidence, based on the response to such inquiry received from the custodian by the provider, that the employee was not listed on the registry as having a substantiated registry-referred incident of abuse, neglect or exploitation. E. **Documentation for other staff**. With respect to all employed or contracted individuals providing direct care who are licensed health care professionals or certified nurse aides, the provider shall maintain documentation reflecting the individual's current licensure as a health care professional or current certification as a nurse aide. F. **Consequences of noncompliance**. The department or other governmental agency having regulatory enforcement authority over a provider may sanction a provider in accordance with applicable law if the provider fails to make an appropriate and timely inquiry of the registry, or fails to maintain evidence of such inquiry, in connection with the hiring or contracting of an employee; or for employing or contracting any person to work as an employee who is listed on the registry. Such sanctions may include a directed plan of correction, civil monetary penalty not to exceed five thousand dollars ($5000) per instance, or termination or non-renewal of any contract with the department or other governmental agency.		
Tag # 1A43.1 General Events Reporting: Individual Reporting	**Standard Level Deficiency**	**Standard Level Deficiency**

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Eff Date: 3/1/2018 **Chapter 19: Provider Reporting Requirements:** **19.2 General Events Reporting (GER):** The purpose of General Events Reporting (GER) is to report, track and analyze events, which pose a risk to adults in the DD Waiver program, but do not meet criteria for ANE or other reportable incidents as defined by the IMB. Analysis of GER is intended to identify emerging patterns so that preventative action can be taken at the individual, Provider Agency, regional and statewide level. On a quarterly and annual basis, DDSD analyzes GER data at the provider, regional and statewide levels to identify any patterns that warrant intervention. Provider Agency use of GER in Therap is required as follows: 1. DD Waiver Provider Agencies approved to provide Customized In- Home Supports, Family Living, IMLS, Supported Living, Customized Community Supports, Community Integrated Employment, Adult Nursing and Case Management must use GER in the Therap system. 2. DD Waiver Provider Agencies referenced above are responsible for entering specified information into the GER section of the secure website operated under contract by Therap according to the GER Reporting Requirements in Appendix B GER Requirements. 3. At the Provider Agency's discretion additional events, which are not required by DDSD, may also be tracked within the GER section of Therap. 4. GER does not replace a Provider Agency's obligations to report ANE or other reportable incidents as described in Chapter 18: Incident Management System. 5. GER does not replace a Provider Agency's obligations related to healthcare coordination,	Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 9 of 15 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 #1** • General Events Report (GER) indicates on 7/25/2017 the Individual received an unspecified injury. (Injury). GER was approved 8/1/2017. • General Events Report (GER) indicates on 8/15/2017 the Individual tripped. (Injury). GER was approved 8/24/2017. • General Events Report (GER) indicates on 11/20/2017 the Individual had a cut on his chin. (Injury). GER was approved 11/29/2017. **Individual #2** • General Events Report (GER) indicates on 5/1/2017 the Individual had a seizure and was at RUST Medical center. (Hospital). GER was approved 5/4/2017. • General Events Report (GER) indicates on 5/29/2017 the Individual had a seizure and was taken to Kaseman Presbyterian Hospital. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 6/9/2017 the Individual had a seizure and was taken to hospital. (Hospital). GER was approved 7/26/2017.	**New / Repeat Finding:** Based on record review, the Agency did not follow the General Events Reporting requirements as indicated by the policy for 7 of 15 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 #1** • General Events Report (GER) indicates on 8/9/2018 the Individual drank bleach from a cup. (Hospital). GER was approved 8/14/2018. **Individual #2** • General Events Report (GER) indicates on 5/23/2018 the Individual was transported to the ER. (Hospital). GER was approved 6/13/2018. • General Events Report (GER) indicates on 6/24/2018 the Individual had a seizure and EMS was contacted. (Seizure). GER was approved 6/27/2018. • General Events Report (GER) indicates on 7/15/2018 the Individual had a seizure and EMS was contacted. (Behavioral Issue). GER was approved 7/18/2018. • General Events Report (GER) indicates on 7/25/2018 the Individual was in the bathroom. (Injury). GER was approved 7/30/2018. **Individual #5**

modifications to the ISP, or any other risk management and QI activities. **Appendix B GER Requirements:** DDSD is pleased to introduce the revised General Events Reporting (GER), requirements. There are two important changes related to medication error reporting: 1. *Effective immediately*, DDSD requires ALL medication errors be entered into Therap GER with the exception of those required to be reported to Division of Health Improvement-Incident Management Bureau. 2. No alternative methods for reporting are permitted. **The following events need to be reported in the Therap GER:** • Emergency Room/Urgent Care/Emergency Medical Services • Falls Without Injury • Injury (including Falls, Choking, Skin Breakdown and Infection) • Law Enforcement Use • Medication Errors • Medication Documentation Errors • Missing Person/Elopement • Out of Home Placement- Medical: Hospitalization, Long Term Care, Skilled Nursing or Rehabilitation Facility Admission • PRN Psychotropic Medication • Restraint Related to Behavior • Suicide Attempt or Threat **Entry Guidance:** Provider Agencies must complete the following sections of the GER with detailed information: profile information, event information, other event information, general	• General Events Report (GER) indicates on 6/25/2017 the Individual had a seizure and was taken to Rust Hospital. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 6/27/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 6/28/2017 the Individual had a seizure and was taken to Rust Hospital. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 7/4/2017 the Individual had a seizure and was taken to Lovelace Hospital. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 7/6/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 8/10/2017. • General Events Report (GER) indicates on 7/13/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 7/15/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 7/26/2017. • General Events Report (GER) indicates on 7/18/2017 the Individual had a seizure and was	• General Events Report (GER) indicates on 6/18/2018 the Individual was experiencing a burning sensation while urinating. (Hospital). GER was approved 6/25/2018. **Individual #6** • General Events Report (GER) indicates on 9/25/2018 the Individual was transported to the hospital. (Hospital). GER was approved 9/28/2018. **Individual #9** • General Events Report (GER) indicates on 5/23/2018 the Individual was agitated. (PRN). GER was approved 7/16/2018. • General Events Report (GER) indicates on 6/8/2018 the Individual was agitated. (PRN). GER was approved 7/13/2018. • General Events Report (GER) indicates on 7/9/2018 the Individual's BSC suggested staff give the Individual a PRN Lorazepam. (Behavioral Issue). GER was approved 7/13/2018. **Individual #13** • General Events Report (GER) indicates on 6/12/2018 the Individual's staff applied ointment and bandage over a cut on his thumb. (First Aid Administered). GER was approved 6/15/2018. **Individual #15** • General Events Report (GER) indicates on 8/30/2018 the Individual walked through the kitchen and out the front door. Overnight staff saw him and offered a ride home. (Behavioral Issue). GER was approved 9/5/2018.

information, notification, actions taken or planned, and the review follow up comments section. Please attach any pertinent external documents such as discharge summary, medical consultation form, etc. Provider Agencies must enter and approve GERs within 2 business days with the exception of Medication Errors which must be entered into GER on at least a monthly basis.	taken to UNMH. (Hospital). GER was approved 8/10/2017. • General Events Report (GER) indicates on 7/24/2017 the Individual had a seizure while at Presbyterian Hospital. (Hospital). GER was approved 8/10/2017. • General Events Report (GER) indicates on 7/27/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 8/10/2017. • General Events Report (GER) indicates on 8/5/2017 the Individual had a seizure and was and Emergency Services were called. (EMS without admission). GER was approved 8/10/2017. • General Events Report (GER) indicates on 8/8/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 8/24/2017. • General Events Report (GER) indicates on 8/9/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 9/10/2017. • General Events Report (GER) indicates on 8/14/2017 the Individual had a seizure and was taken to hospital. (Hospital). GER was approved 8/24/2017. • General Events Report (GER) indicates on 8/16/2017 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was approved 8/24/2017.	• General Events Report (GER) indicates on 10/1/2018 the Individual eloped through the front door. (Behavioral Issue). GER was approved 10/8/2018. • General Events Report (GER) indicates on 5/19/2018 the Individual slammed the sliding door and locked it to prevent staff from following him. He was located at the library. (Behavioral Issue). GER was approved 6/20/2018.

	• General Events Report (GER) indicates on 8/22/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 8/23/2017 the Individual had a seizure and was taken to V.A. Hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 8/25/2017 the Individual had an anxiety attack and was taken to Lovelace Hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 8/27/2017 the Individual had a seizure and was taken to Sandoval Regional Hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 8/29/2017 the Individual had a seizure and was taken to V.A. Hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 8/30/2017 the Individual had a seizure and was taken to hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 9/9/2017 the Individual had a seizure and was taken to Cibola General Hospital. (Hospital). GER was approved 9/11/2017. • General Events Report (GER) indicates on 9/15/2017 the Individual had a seizure and was	

	taken to hospital. (Hospital). GER was approved 9/20/2017. • General Events Report (GER) indicates on 10/15/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 10/23/2017. • General Events Report (GER) indicates on 10/18/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 10/23/2017. • General Events Report (GER) indicates on 10/28/2017 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was approved 11/3/2017. • General Events Report (GER) indicates on 11/19/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 11/29/2017. • General Events Report (GER) indicates on 10/24/2017 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 11/29/2017. • General Events Report (GER) indicates on 11/25/2017 the Individual was injured while training her horse. (Injury). GER was approved 11/29/2017. • General Events Report (GER) indicates on 11/26/2017 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was approved 11/29/2017.	

	• General Events Report (GER) indicates on 12/2/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 12/12/2017. • General Events Report (GER) indicates on 12/5/2017 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 12/12/2017. • General Events Report (GER) indicates on 1/2/2018 the Individual had a seizure and was taken to Presbyterian Hospital. (Hospital). GER was approved 1/5/2018. • General Events Report (GER) indicates on 1/9/2018 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was approved 1/12/2018. • General Events Report (GER) indicates on 1/18/2018 the Individual had a seizure and was taken to UNMH. (Hospital). GER was approved 1/23/2018. • General Events Report (GER) indicates on 3/31/2018 the Individual had a seizure and was taken to Kaseman Hospital. (Hospital). GER was approved 4/10/2018. • General Events Report (GER) indicates on 4/4/2018 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was approved 4/10/2018. • General Events Report (GER) indicates on 4/24/2018 the Individual had a seizure and was	

	taken to Presbyterian Hospital. (Hospital). GER was pending approval. • General Events Report (GER) indicates on 5/6/2018 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was approved 5/14/2018. • General Events Report (GER) indicates on 5/10/2018 the Individual was AWOL. (AWOL/Missing person). GER was pending approval. • General Events Report (GER) indicates on 5/11/2018 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was pending approval. • General Events Report (GER) indicates on 5/13/2018 the Individual had a seizure and Emergency Services were called. (EMS without admission). GER was pending approval. **Individual #6** • General Events Report (GER) indicates on 10/13/2017 the Individual was taken to Emergency Room for a small opening in an incision site (ER). GER was approved 11/3/2017. **Individual #9** • General Events Report (GER) indicates on 4/9/2018 the Individual was injured while playing volleyball. (Injury). GER was approved 4/12/2018. **Individual #11** • General Events Report (GER) indicates on 5/14/2017 the Individual fell and bumped his head.	

	(Fall without Injury). GER was approved 5/24/2017. **Individual #13** • General Events Report (GER) indicates on 9/15/2017 the Individual was taken to the Emergency Room for complaints of chest pain. (ER). GER was approved 9/20/2017. **Individual #14** • General Events Report (GER) indicates on 10/16/2017 the Individual cut herself while chopping tomatoes. (Injury). GER was approved 10/24/2017. **Individual #15** • General Events Report (GER) indicates on 12/13/2017 the Individual was AWOL. (AWOL/Missing person). GER was approved 12/18/2017. **The following events were not reported in the General Events Reporting System as required by policy:** **Individual #2** • Documentation reviewed indicates on 5/10/2018 the Individual had a seizure and was taken to Presbyterian Hospital (Hospital). No GER was found. **Individual #8** • Documentation reviewed indicates on 2/22/2018 the Individual fell and was seen in the Emergency Department (Injury). No GER was found. **Individual #13**	

	• Documentation reviewed indicates on 1/3/2018 the Individual was seen in Urgent Care (Other). No GER was found. • Documentation reviewed indicates on 3/7/2018 the Individual was seen in Urgent Care (Other). No GER was found.	
Standard of Care	**Routine Survey Deficiencies May 11 – 18, 2018**	**Verification survey New and Repeat Deficiencies November 14 – 30, 2018**
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 Administrative Case File (Other Required Documents)	**Standard Level Deficiency**	Complete
Tag # 1A38 Living Care Arrangement / Community Inclusion Reporting Requirements	**Standard Level Deficiency**	Complete
Tag # LS14 Residential Case File (ISP and Healthcare Requirements)	**Condition of Participation Level Deficiency**	Complete
Tag # LS14.1 Residential Case File (Other Req. Documentation)	**Standard Level Deficiency**	Complete
Service Domain: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements. The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved waiver.*		
Tag # 1A20 Direct Support Personnel Training	**Condition of Participation Level Deficiency**	Complete
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	Complete
Tag # 1A37 Individual Specific Training	**Condition of Participation Level Deficiency**	Complete
Service Domain: Health and Welfare – *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		

Tag # 1A08.2 Administrative Case File: Healthcare Requirements & Follow-up	**Condition of Participation Level Deficiency**	Complete
Tag # 1A09 Medication Delivery Routine Medication Administration	**Condition of Participation Level Deficiency**	Complete
Tag # 1A09.1 Medication Delivery PRN Medication Administration	**Condition of Participation Level Deficiency**	Complete
Tag # 1A09.1.0 Medication Delivery PRN Medication Administration	**Standard Level Deficiency**	Complete
Tag # 1A09.2 Medication Delivery Nurse Approval for PRN Medication	**Condition of Participation Level Deficiency**	Complete
Tag # 1A31 Client Rights/Human Rights	**Condition of Participation Level Deficiency**	Complete
Tag # 1A33 Board of Pharmacy: Med. Storage	**Standard Level Deficiency**	Complete
Tag # LS25 Residential Health & Safety (Supported Living & Family Living)	**Condition of Participation Level Deficiency**	Complete
Service Domain: Medicaid Billing/Reimbursement – *State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*		
Tag #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 # 1A32 **Administrative Case File: Individual Service Plan Implementation**	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A32.1 **Administrative Case File: Individual Service Plan**	**Provider:**	

Implementation *(Not Completed at Frequency)*	**State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A26 Consolidated On-line Registry Employee Abuse Registry	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)***: →** **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to effect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)***: →**	
Tag # 1A43.1 General Events Reporting: Individual 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?)***:** →	

Date: January 8, 2019

To: Jason Buckles, Executive Director
Provider: A Better Way of Living, Inc.
Address: 202 Central Ave SE Suite 200
State/Zip: Albuquerque, New Mexico 87102

E-mail Address: JasonB@ABetterWayNM.org

Region: Metro
Routine Survey: May 11 – 18, 2018
Verification Survey: November 14 – 30, 2018

Service Surveyed: ***2007:*** Independent Living and Supported Employment
2012: Supported Living, Customized Community Supports, Community Integrated Employment Services and Customized In-Home Supports

Survey Type: Verification

Dear Mr. Buckles;

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

The Plan of Correction process is now complete.

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

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

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

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

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

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