Date:	January 2, 2020
To:	Bill Kesatie, Executive Director
Provider:	Su Vida Services Incorporated
Address:	8501 Candelaria, Building A
City, State, Zip:	Albuquerque, New Mexico 87112
E-mail Address:	billkesatie@suvidaservices.com
Region:	Metro, Northwest, Southwest
Routine Survey:	July 5 - 11, 2019
Verification Survey:	December 18 – 23, 2019
Program Surveyed:	Developmental Disabilities Waiver
Service Surveyed:	***2018:*** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports**.**
Survey Type:	Verification
Team Leader:	Lora Norby, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau
Team Member:	Roxanne Garcia, BA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau; Heather Driscoll, AA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau

Dear Bill Kesatie;

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* July 5 - 11, 2019.

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

Partial Compliance with Standard Level Tags and Conditions of Participation Level Tags: This determination is based on noncompliance with one to five (1 – 5) Condition of Participation Level Tags *(refer to Attachment D for details)*. The attached QMB Report of Findings indicates Standard Level and Condition of Participation Level deficiencies identified and requires completion and implementation of a Plan of Correction.

The following tags are identified as Condition of Participation Level:

- Tag # 1A32 Administrative Case File: Individual Service Plan Implementation ***(New / Repeat Finding)***
- Tag # 1A31 Client Rights/Human Rights ***(Repeat Finding)***

The following tags are identified as Standard Level:

- Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements) ***(Repeat Finding)***

However, due to the new/repeat 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**
   5301 Central Ave. NE Suite 400, New Mexico 87108
   MonicaE.Valdez@state.nm.us

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 Monica Valdez at 505-273-1930 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

Lora Norby

Lora Norby
Team Lead/Healthcare Surveyor
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	December 18, 2019
Contact:	**Su Vida Services Incorporated** Bill Kesatie, Executive Director / SC **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor
On-site Entrance Conference Date:	December 20, 2019
Present:	**Su Vida Services Incorporated** Bill Kesatie, Executive Director / SC **DOH/DHI/QMB** Lora Norby, Team Lead/Healthcare Surveyor Heather Driscoll, AA, Healthcare Surveyor
Exit Conference Date:	December 23, 2019
Present:	**Su Vida Services Incorporated** Bill Kesatie, Executive Director / SC **DOH/DHI/QMB** Lora Norby, Healthcare Surveyor Roxanne Garcia, BA, Healthcare Surveyor Wolf Krusemark, BFA, Healthcare Surveyor Supervisor (via phone)
Administrative Locations Visited	1
Total Sample Size	18 0 - *Jackson* Class Members 18 - Non-*Jackson* Class Members 3 - Supported Living 11 - Family Living 4 - Customized In-Home Supports 14 - Customized Community Supports
Persons Served Records Reviewed	18
Direct Support Personnel Interviewed during Routine Survey	21
Direct Support Personnel Records Reviewed	98
Substitute Care/Respite Personnel Records Reviewed	30
Service Coordinator Records Reviewed	2
Nurse Interviews completed during Routine Survey	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 Living Care Arrangements and Community Inclusion are as follows:

Service Domain: Service Plan: ISP Implementation - *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)

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.*

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 / Knowledge
- **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 (*Note: No extensions are granted for the IRF)*.
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, Valerie V. Valdez at valerie.valdez@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 that no deficiencies at the Condition of Participation Level were found. 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 total Tags with 0 to 5 Condition of Participation Level Tags with 75% to 100% of the survey sample affected in any Condition of Participation Level 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	
Total 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** Total Tags with **75 to 100%** of the Individuals in the sample cited in any CoP Level 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** 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: **Su Vida Services Incorporated – Metro, Northwest, Southwest**
Program: Developmental Disabilities Waiver
Service: ***2018:*** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports
Survey Type: Verification
Routine Survey: **July 5 - 11, 2019**
Verification Survey: **December 18 – 23, 2019**

Standard of Care	Routine Survey Deficiencies July 5 - 11, 2019	Verification Survey New and Repeat Deficiencies December 18 – 23, 2019
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	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
NMAC 7.26.5.16.C and D Development of the ISP. Implementation of the ISP. The ISP shall be implemented according to the timelines determined by the IDT and as specified in the ISP for each stated desired outcomes and action plan. C. The IDT shall review and discuss information and recommendations with the individual, with the goal of supporting the individual in attaining desired outcomes. The IDT develops an ISP based upon the individual's personal vision statement, strengths, needs, interests and preferences. The ISP is a dynamic document, revised periodically, as needed, and amended to reflect progress towards personal goals and achievements consistent with the individual's future vision. This regulation is consistent with standards established for individual plan development as set forth by the commission on the accreditation of rehabilitation facilities (CARF) and/or other program accreditation approved and adopted by the developmental disabilities division and the department of health. It is the policy of the developmental disabilities 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	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. 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 18 individuals. **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #17 • None found regarding: Live Outcome/Action Step: "...will utilize adaptive equipment to call his nighttime staff" for 3/2019. Action step is to be completed 1 time per week. • None found regarding: Fun Outcome/Action Step: "...will let staff know he wants to communicate with his family" for 5/2019. Action step is to be completed 1 time per week.	**New / Repeat Finding**: After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on 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 3 of 18 individuals. **Supported Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #17 • None found regarding: Live Outcome/Action Step: "...will try an app of his own choice" for 10/2019 – 11/2019. Action step is to be completed 2 times per month. • None found regarding: Fun/Relationship Outcome/Action Step: "...will let staff know he wants to communicate with his family" for 10/2019. Action step is to be completed 1 time per week.

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; Re-Issue: 12/28/2018; Eff 1/1/2019 **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.	**Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #11 • None found regarding: Live Outcome/Action Step: "...will use the key to open the mail box" for 3/2018 - 5/2019. Action step is to be completed 3 times per week. • None found regarding: Live Outcome/Action Step: "...will get the mail" for 3/2018 - 5/2019. Action step is to be completed 3 times per week. Individual #12 • None found regarding: Live Outcome/Action Step: "...will take out the bathroom trash" for 3/2019 - 5/2019. Action step is to be completed 1 time per week. • None found regarding: Work/Learn Outcome/Action Step: "...will remove price tags without damaging items" for 3/2019 - 5/2019. Action step is to be completed 1 time per week. • None found regarding: Work/Learn Outcome/Action Step: "...will neatly straighten clothes on rack" for 3/2019 - 5/2019. Action step is to be completed 1 time per week. • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area: **Agency's Outcomes/Action Steps are as follows:** ◦ "House chores/duties." **Annual ISP (7/28/2018 – 7/27/2019) Outcomes/Action Steps are as follows:**	• None found regarding: Fun/Relationship Outcome/Action Step: "...will contact family members of his choice" for 10/2019 – 11/2019. Action step is to be completed 1 time per week. **Family Living Data Collection/Data Tracking/Progress with regards to ISP Outcomes:** Individual #12 • Review of Agency's documented Outcomes and Action Steps do not match the current ISP Outcomes and Action Steps for Live area: **Agency's Outcomes/Action Steps are as follows:** ◦ "Will wipe down the toilet." **Annual ISP (7/28/2019 – 7/27/2020) Outcomes/Action Steps are as follows:** ◦ "Will wipe down the sink after he brushes his teeth." **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Work/Learn Outcome/Action Step: "...will research acting classes in the metro area" for 10/2019 - 11/2019. Action step is to be completed 1 time per month. • None found regarding: Work/Learn Outcome/Action Step: "With assistance will gain confidence in her reading skills and participate in acting classes in the metro area" for 10/2019 - 11/2019. Action step is to be completed 1 time per month.

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.	◦ "...will fold shirts." **Customized In-Home Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #4 • None found regarding: Health/Other Outcome/Action Step: "...will work with her substance abuse counselor" for 4/2019. Action step is to be completed 1 time per week. **Customized Community Supports Data Collection/Data Tracking/Progress with regards to ISP Outcomes**: Individual #1 • None found regarding: Work/Learn Outcome/Action Step: "...will research acting classes in the metro area" for 3/2019 - 5/2019. Action step is to be completed 1 time per month. • None found regarding: Health/Other Outcome/Action Step: "...will choose a physical activity of her choice" for 3/2019 - 5/2019. Action step is to be completed 2 times per week. • None found regarding: Health/Other Outcome/Action Step: "...will do the physical activity and add more time as she gains endurance" for 3/2019. Action step is to be completed 2 times per week.	Based on the Agency's Plan of Correction approved on 9/27/2019, "The QA coordinator reviews approximately 8 files monthly so that all files are reviewed by the end of the year. The Executive Director reviews 1 - 2 of the QA Officer's files monthly so that there is a check on the QA officer's files, too." No evidence of ongoing monthly review by the QA officer was provided during the Verification Survey completed December 18 – 23, 2019.

Tag # LS14 Residential Service Delivery Site Case File (ISP and Healthcare requirements)	Condition of Participation Level Deficiency	Standard Level Deficiency
Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **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	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 a complete and confidential case file in the residence for 7 of 12 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete or not current: **Annual ISP:** • Not Current (#8) **ISP Teaching and Support Strategies:** ***Individual #8:*** *TSS not found for the Live Outcome Statement / Action Steps:* • "... will choose a household chore to complete." • "... will complete a gardening task." ***Individual #14:*** *TSS not found for the Live Outcome Statement / Action Steps:* • "... will use her visual and audio cues to match numbers to their equal amount." ***Individual #17:*** *TSS not found for the Live Outcome Statement / Action Steps:* • "...will purchase the AT device through the AT fund." • "...will try an app of his choice 2 times a month."	**Repeat Finding**: Based on record review, the Agency did not maintain a complete and confidential case file in the residence for 1 of 12 Individuals receiving Living Care Arrangements. Review of the residential individual case files revealed the following items were not found, incomplete or not current: **ISP Teaching and Support Strategies:** ***Individual #17:*** *TSS not found for the Live Outcome Statement / Action Steps:* • "...will purchase the AT device through the AT fund." • "...will try an app of his choice 2 times a month." **Health Care Plans:** • Paralysis (#17) **Medical Emergency Response Plans:** • Aspiration (#17) • Seizures (#17)

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. **20.5.3 Health Passport and Physician Consultation Form:** All Primary and Secondary Provider Agencies must use the Health Passport and Physician Consultation form from the Therap system. This standardized document contains individual, physician and emergency contact information, a complete list of current medical diagnoses, health and safety risk factors, allergies, and information regarding insurance, guardianship, and advance directives. The Health Passport also includes a standardized form to use at medical appointments called the Physician Consultation form. The Physician Consultation form contains a list of all current medications. Requirements for the Health Passport and Physician Consultation form are: 2. The Primary and Secondary Provider Agencies must ensure that a current copy of the Health Passport and Physician Consultation forms are printed and available at all service delivery sites. Both forms must be reprinted and placed at all service delivery sites each time the e-CHAT is updated for any reason and whenever there is a change to contact information contained in the IDF.	***Individual #19:*** *TSS not found for the following Live Outcome Statement / Action Steps:* • "... will collect and organize her daily receipts for the week." • "... will review her spending for the week." • "... will manage the amount to be utilized for spending per week." *TSS not found for the following Fun/Relationship Outcome Statement / Action Steps:* • "... will research a hotel and restaurant she wants to go to for a trip." **Healthcare Passport:** • Not Found (#13) • Not Current (#8, 19) • Did not contain information regarding insurance (#5) **Health Care Plans:** • Bowel and Bladder (#17) • Gerd (#3) • Paralysis (#17) • Seizures (#3, 17) • Status of Care/Hygiene (#13) **Medical Emergency Response Plans:** • Aspiration (#17) • Seizures (#17)	

Chapter 13: Nursing Services: **13.2.9 Healthcare Plans (HCP):** 1. At the nurse's discretion, based on prudent nursing practice, interim HCPs may be developed to address issues that must be implemented immediately after admission, readmission or change of medical condition to provide safe services prior to completion of the e-CHAT and formal care planning process. This includes interim ARM plans for those persons newly identified at moderate or high risk for aspiration. All interim plans must be removed if the plan is no longer needed or when final HCP including CARMPs are in place to avoid duplication of plans. 2. In collaboration with the IDT, the agency nurse is required to create HCPs that address all the areas identified as required in the most current e-CHAT summary **13.2.10 Medical Emergency Response Plan (MERP):** 1. The agency nurse is required to develop a Medical Emergency Response Plan (MERP) for all conditions marked with an "R" in the e-CHAT summary report. The agency nurse should use her/his clinical judgment and input from the Interdisciplinary Team (IDT) to determine whether shown as "C" in the e-CHAT summary report or other conditions also warrant a MERP. 2. MERPs are required for persons who have one or more conditions or illnesses that present a likely potential to become a life-threatening situation.		

Standard of Care	Routine Survey Deficiencies July 5 - 11, 2019	Verification Survey New and Repeat Deficiencies December 18 – 23, 2019
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 # 1A31 Client Rights/Human Rights	**Condition of Participation Level Deficiency**	**Condition of Participation Level Deficiency**
NMAC 7.26.3.11 RESTRICTIONS OR LIMITATION OF CLIENT'S RIGHTS: A. A service provider shall not restrict or limit a client's rights except: (1) where the restriction or limitation is allowed in an emergency and is necessary to prevent imminent risk of physical harm to the client or another person; or (2) where the interdisciplinary team has determined that the client's limited capacity to exercise the right threatens his or her physical safety; or (3) as provided for in Section 10.1.14 [now Subsection N of 7.26.3.10 NMAC]. B. Any emergency intervention to prevent physical harm shall be reasonable to prevent harm, shall be the least restrictive intervention necessary to meet the emergency, shall be allowed no longer than necessary and shall be subject to interdisciplinary team (IDT) review. The IDT upon completion of its review may refer its findings to the office of quality assurance. The emergency intervention may be subject to review by the service provider's behavioral support committee or human rights committee in accordance with the behavioral support policies or other department regulation or policy. C. The service provider may adopt reasonable program policies of general applicability to clients served by that service provider that do not violate client rights. [09/12/94; 01/15/97; Recompiled 10/31/01]	After an analysis of the evidence it has been determined there is a significant potential for a negative outcome to occur. Based on record review, the Agency did not ensure the rights of Individuals was not restricted or limited for 2 of 18 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Support Plans and/or Behavior Crisis Intervention Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#6, 18) A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • Physical Restraint - No evidence found of Human Rights Committee approval. (Individual #6) • Line of sight - No evidence found of Human Rights Committee approval. (Individual #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 ensure the rights of Individuals was not restricted or limited for 2 of 18 Individuals. A review of Agency Individual files found no documentation of Positive Behavior Support Plans and/or Behavior Crisis Intervention Plans, which contain restrictions being reviewed at least quarterly by the Human Rights Committee. (#6, 18) A review of Agency Individual files indicated Human Rights Committee Approval was required for restrictions. No documentation was found regarding Human Rights Approval for the following: • Physical Restraint - No evidence found of Human Rights Committee approval. (Individual #6) • Line of sight - No evidence found of Human Rights Committee approval. (Individual #18)

Developmental Disabilities (DD) Waiver Service Standards 2/26/2018; Re-Issue: 12/28/2018; Eff 1/1/2019 **Chapter 2: Human Rights:** Civil rights apply to everyone, including all waiver participants, family members, guardians, natural supports, and Provider Agencies. Everyone has a responsibility to make sure those rights are not violated. All Provider Agencies play a role in person-centered planning (PCP) and have an obligation to contribute to the planning process, always focusing on how to best support the person. **Chapter 3 Safeguards: 3.3.1 HRC Procedural Requirements:** 1. An invitation to participate in the HRC meeting of a rights restriction review will be given to the person (regardless of verbal or cognitive ability), his/her guardian, and/or a family member (if desired by the person), and the Behavior Support Consultant (BSC) at least 10 working days prior to the meeting (except for in emergency situations). If the person (and/or the guardian) does not wish to attend, his/her stated preferences may be brought to the meeting by someone whom the person chooses as his/her representative. 2. The Provider Agencies that are seeking to temporarily limit the person's right(s) (e.g., Living Supports, Community Inclusion, or BSC) are required to support the person's informed consent regarding the rights restriction, as well as their timely participation in the review. 3. The plan's author, designated staff (e.g., agency service coordinator) and/or the CM makes a written or oral presentation to the HRC. 4. The results of the HRC review are reported in writing to the person supported, the guardian, the BSC, the mental health or other specialized therapy provider, and the CM within three working days of the meeting.		

5. HRC committees are required to meet at least on a quarterly basis. 6. A quorum to conduct an HRC meeting is at least three voting members eligible to vote in each situation and at least one must be a community member at large. 7. HRC members who are directly involved in the services provided to the person must excuse themselves from voting in that situation. Each HRC is required to have a provision for emergency approval of rights restrictions based upon credible threats of harm against self or others that may arise between scheduled HRC meetings (e.g., locking up sharp knives after a serious attempt to injure self or others or a disclosure, with a credible plan, to seriously injure or kill someone). The confidential and HIPAA compliant emergency meeting may be via telephone, video or conference call, or secure email. Procedures may include an initial emergency phone meeting, and a subsequent follow-up emergency meeting in complex and/or ongoing situations. 8. The HRC with primary responsibility for implementation of the rights restriction will record all meeting minutes on an individual basis, i.e., each meeting discussion for an individual will be recorded separately, and minutes of all meetings will be retained at the agency for at least six years from the final date of continuance of the restriction. **3.3.3 HRC and Behavioral Support:** The HRC reviews temporary restrictions of rights that are related to medical issues or health and safety considerations such as decreased mobility (e.g., the use of bed rails due to risk of falling during the night while getting out of bed). However, other temporary restrictions may be implemented because of health and safety considerations arising from behavioral issues. Positive Behavioral Supports (PBS) are mandated		

and used when behavioral support is needed and desired by the person and/or the IDT. PBS emphasizes the acquisition and maintenance of positive skills (e.g. building healthy relationships) to increase the person's quality of life understanding that a natural reduction in other challenging behaviors will follow. At times, aversive interventions may be temporarily included as a part of a person's behavioral support (usually in the BCIP), and therefore, need to be reviewed prior to implementation as well as periodically while the restrictive intervention is in place. PBSPs not containing aversive interventions do not require HRC review or approval. Plans (e.g., ISPs, PBSPs, BCIPs PPMPs, and/or RMPs) that contain any aversive interventions are submitted to the HRC in advance of a meeting, except in emergency situations. **3.3.4 Interventions Requiring HRC Review and Approval:** HRCs must review prior to implementation, any plans (e.g. ISPs, PBSPs, BCIPs and/or PPMPs, RMPs), with strategies, including but not limited to: 1. response cost; 2. restitution; 3. emergency physical restraint (EPR); 4. routine use of law enforcement as part of a BCIP; 5. routine use of emergency hospitalization procedures as part of a BCIP; 6. use of point systems; 7. use of intense, highly structured, and specialized treatment strategies, including level systems with response cost or failure to earn components; 8. a 1:1 staff to person ratio for behavioral reasons, or, very rarely, a 2:1 staff to person ratio for behavioral or medical reasons; 9. use of PRN psychotropic medications; 10. use of protective devices for behavioral purposes (e.g., helmets for head banging, Posey		

gloves for biting hand); 11. use of bed rails; 12. use of a device and/or monitoring system through PST may impact the person's privacy or other rights; or 13. use of any alarms to alert staff to a person's whereabouts. **3.4 Emergency Physical Restraint (EPR):** Every person shall be free from the use of restrictive physical crisis intervention measures that are unnecessary. Provider Agencies who support people who may occasionally need intervention such as Emergency Physical Restraint (EPR) are required to institute procedures to maximize safety. **3.4.5 Human Rights Committee:** The HRC reviews use of EPR. The BCIP may not be implemented without HRC review and approval whenever EPR or other restrictive measure(s) are included. Provider Agencies with an HRC are required to ensure that the HRCs: 1. participate in training regarding required constitution and oversight activities for HRCs; 2. review any BCIP, that include the use of EPR; 3. occur at least annually, occur in any quarter where EPR is used, and occur whenever any change to the BCIP is considered; 4. maintain HRC minutes approving or disallowing the use of EPR as written in a BCIP; and 5. maintain HRC minutes of meetings reviewing the implementation of the BCIP when EPR is used.		

Standard of Care	Routine Survey Deficiencies July 5 - 11, 2019	Verification Survey New and Repeat Deficiencies December 18 – 23, 2019
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 # 1A32.2 Individual Service Plan Implementation (Residential Implementation)	**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	**Standard Level Deficiency**	**COMPLETE**
Tag # 1A22 Agency Personnel Competency	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A37 Individual Specific Training	**Standard Level Deficiency**	**COMPLETE**
Service Domain: Health and Welfare - *The state, on an ongoing basis, identifies, addresses and seeks to prevent occurrences of abuse, neglect and exploitation. Individuals shall be afforded their basic human rights. The provider supports individuals to access needed healthcare services in a timely manner.*		
Tag # 1A05 General Provider Requirements / Agency Policy and Procedures Requirements	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # 1A15 Healthcare Documentation - Nurse Availability / Knowledge	**Condition of Participation Level Deficiency**	**COMPLETE**
Tag # LS25 Residential Health and Safety (Supported Living & Family Living)	**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 # LS26 Supported Living Reimbursement	**Standard Level Deficiency**	**COMPLETE**

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Date Due
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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	
Tag # LS14 Residential Service Delivery Site Case File (ISP and 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 affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

	Verification Survey Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Tag # 1A31 Client Rights/Human Rights	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: February 10, 2020

To: Bill Kesatie, Executive Director
Provider: Su Vida Services Incorporated
Address: 8501 Candelaria, Building A
City, State, Zip: Albuquerque, New Mexico 87112

E-mail Address: billkesatie@suvidaservices.com

Region: Metro, Northwest, Southwest
Routine Survey: July 5 - 11, 2019
Verification Survey: December 18 – 23, 2019

Program Surveyed: Developmental Disabilities Waiver

Service Surveyed: ***2018:*** Supported Living, Family Living, Customized In-Home Supports, Customized Community Supports**.**

Survey Type: Verification

Dear Mr. Kesatie:

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,

Monica Valdez, BS

Monica Valdez, BS
Healthcare Surveyor Advanced/Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.20.2.DDW.D2601.1,3,5.VER.09.20.041